NEXT ANNUAL SESSIONS
American Medical Association, Kansas City, May 11–15, 1936
California Medical Association, Coronado, May 25–28, 1936

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CALIFORNIA AND WESTERN MEDICINE

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this journal.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

ANNUAL SESSION OF 1936: HEADQUARTERS AT HOTEL CORONADO

Hotel Reservations at This Year's Annual Session.—The 1936 annual session of the California Medical Association will have as its headquarters the historic and ever-attractive Hotel del Coronado, and it should not be a surprise to members who have not made reservations to date to learn that only twenty-five rooms are still at their disposal. This means that many members who attend the coming session will be obliged to seek hotel accommodations in San Diego, across the bay, and orders for even these should not be too long delayed. A letter to Association Secretary Warnshuis will bring you a list of hotels.

* * *

Scientific Program.—The Committee on Scientific Program at a recent meeting in Los Angeles reported that the programs for the general meetings and also the numerous sections were well in hand; the chief worry being, not as to sufficient addresses or the attendance, but rather whether the accommodations for meetings would be adequate comfortably to care for members who may wish to attend the sections and hear the presentations of guest speakers or essayists.

With the yearly growth of the State Association, the group of members who offer papers for the scientific programs becomes greater, and, as a consequence, the Committee on Scientific Program for some time past has been forced to decline a considerable number of excellent essays because each section is permitted to have only a certain amount of time, that all the various activities may properly fit, one into the other. Members, therefore, who have in mind papers which they think worthy of consideration, as of interest and value to other members, should write practically a year ahead to the Association Secretary who, as chairman of the Committee on Scientific Program, will be glad to give full information on the requirements and standards laid down for such scientific contributions.

* * *

The Coronado Session Dates Are May 25-28, 1936.—It is suggested that you mark your calendar with these dates and make a mental re-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

solve to try to attend the meetings of this year. Many subjects of importance in relation to both scientific and organized medicine will be up for consideration. Those who attend annual session meetings always feel they profit, not only from hearing papers and discussions, but also from the pleasant contacts made with colleagues from all parts of the State. The meetings, too, are of value to all members, no matter how long they have been in practice or what is the period of their California Medical Association membership, and a cordial invitation is extended to every member to attend. Try, therefore, to be among those who will answer "Present" at Coronado on May 25-28.

EXPERT MEDICAL TESTIMONY: A RECENT LEGAL ENCOUNTER

Claims of a Los Angeles Attorney.—In December last, a member of the Los Angeles County Medical Association was served with a court subpoena to appear with certain records and give a deposition on his professional findings concerning a patient who had been under his observation. He learned that the attorney for the plaintiff intended to demand expert testimony, without giving him the fee for such testimony; client and lawyer contending that, under Section 2021 of the Civil Code of California, a new code provision passed by the last legislature, the physician was so obligated. Upon the advice of his personal attorney, he stated his objections to being questioned; but in order to avoid the delays incident to a citation for contempt of court, he gave his testimony on the questions submitted, all subject, however, to his objections thereto.

When our attention was called to the matter, we wrote to the general counsel of the Association, Mr. Hartley Peart, and his letter of reply may be found on page 136 of this issue.

Mention is here made of the affair lest further demands of this nature be presented to members of the Association. All that is needed to bring such "demanding attorneys" to their senses is the willingness of one of the physicians so cited to refuse to answer on matters of opinion and permit himself to be haled before a superior court on the charge of contempt; after which the matter can be threshed out and settled.

Between attorneys-at-law in the legislature, who elaborate confusing statutes, and others in private practice, who seek to add more confusion, ordinary citizens are certainly, at times, submitted to much inconvenience in combating such nuisances.

ON SOME ARTICLES AND ITEMS IN THE CURRENT NUMBER

Every Issue Contains Some Articles of Special Interest.—In each number of the official Journal an effort is made to present a composite of the California Medical Association's scientific and organization activities in the hope that every reader may find something to his special liking or needs. When, occasionally, attention is called to certain articles, it is not so much because of supposedly superior scientific or literary merit, but rather that the articles mentioned, on account of other reasons existing at the time, may be of immediate or general interest and importance. Thus, in the current issue, mention may be made of the items listed below:

* * *

Infection of Two Laboratory Workers in California with Psittacosis and Tularemia.—From time to time, reports of cases of infection of laboratory workers find places in the literature,* and to these may be added two case reports in this issue; one of psittacosis and the other of tularemia, well worthy of perusal. It is gratifying to know that both patients went on to good recovery in spite of the severe illness each experienced. In this connection, also, may be noted the unfortunate experience of Dr. H. E. Hasseltine of the United States Public Health Service, who contracted psittacosis in the recent work of dismantling the Pasadena laboratory of the State Board of Health; but who, likewise, after a critical sickness, happily recovered.

* * *

"Baking Soda-Sodium Fluorid" Poisonings in San Francisco.—A few weeks ago the lay press contained, day after day, accounts of the illness and deaths resulting from the use of what was supposed to be poisoned baking soda, but which later was shown to be baking soda contaminated by sodium fluorid. After immediate and exhaustive investigation by the Director of Public Health of the City and County of San Francisco, the conditions under which this accident occurred were laid bare. The two articles, one entitled "Poisoning Due to the Ingestion of a Mixture of Sodium Bicarbonate-Sodium Fluorid," by Dr. J. C. Geiger, and the other captioned "Acute Fluorin Poisoning," by Dr. Jesse L. Carr, commenting on the need of more efficient statutory regulations of salvaged goods, make interesting reading. It is, therefore, to be hoped that both State and local regulations, adequate to prevent a recurrence of such accidents, will be enacted in the near future.

* * *

Conference of County Society Secretaries.—On Saturday, January 18, the secretaries of the component county societies were the official guests of the California Medical Association in an all-day meeting held in San Francisco. The program was printed in last month's issue (page 52), and Association Secretary Warnshuis will no doubt present further information thereon. The officers of the State Association felt that this conference, in its initial meeting, had more than justified itself; a sentiment heartily concurred in by the representatives of the county societies who were present.

It is generally agreed that the administrative officer of a county society who carries most of

* See October, 1935, CALIFORNIA AND WESTERN MEDICINE, page 260 (Doctor Hasseltine); and January, 1936, issue, page 64 (the late Miss Pabst).

its burdens is the secretary. If the county secretary is familiar with the organization work of the State Association, he can become a powerful factor in creating additional and harmonious effort for the attainment of the policies to which the parent organization is pledged. At San Francisco, on Saturday morning, the State Association officers presented outlines of their work and problems. In the afternoon, round-table discussions were had of the work of the Association and its component societies. Many of these secretaries will be among the delegates at the next annual session, and this preliminary conference will make for better understanding of the numerous subjects which will be presented to the House of Delegates at Coronado.

* * *

California Medical Association Council Meeting of January 19.—The Council put in an entire day discussing items on an extensive docket and even then found it difficult adequately to consider all the problems submitted. The complete minutes are printed in this issue.†

One of the important matters was the report of the Judicial Council of the American Medical Association on the appeal of two members of the Los Angeles County Medical Association who, some time ago, were expelled by that unit. An inspection of the blackface subheadings of the other items of business will reveal decisions taken on other problems facing the Association. Members are urged to read the minutes, recollecting that the references to subjects are much condensed when written up as minutes. Local councilors and the Association Secretary will be happy to give additional information to members who desire further knowledge on any topics.

STATE ASSOCIATION DELEGATES: HOW ONE LARGE SOCIETY SELECTS ITS DELEGATES AND ALTERNATES

House of Delegates the Association's Supreme Body: Its Important Work.—The increasing importance of the medical-economic problems which, at each year's annual session come before the House of Delegates, makes it more than ever apparent that the election of delegates and alternates should not be a haphazard function, but rather a duty to be looked upon as one of the serious responsibilities of a component county society, and so to be construed by all members. The offices of delegates and alternates should not be regarded as positions of little moment, to be given as transient expressions of courtesy to one member this year, and to another the next. On the contrary, a county unit's members, prior to electing their delegates and alternates should ask themselves: Who, among our number, can best represent the points of view of our society on the business problems of the State Association and its component county units, and who, among us, may be of greatest coöperative service with other delegates in acting on policies vital to the further development of both our Association and scientific and organized medicine?

In smaller societies the overemphasizing of personal regard or other affiliations may, at times, lead to danger and prove not always to result in the best of possible selections. In larger organizations with hundreds of members—many of whom, month in and month out, pay only nominal attention to the general problems of their organization—the task of selection is also no easy matter.

* * *

How the Los Angeles County Medical Association Has Solved This Problem.—The Los Angeles County Medical Association has more than 2,200 members and is entitled, therefore, on the basis of one delegate for every fifty members, to forty-one delegates. Its task is to determine who shall be its forty-one delegates and alternates.

In 1933, the Board of Councilors of that society solved its problem, not through the appointment of a nominating committee, nor even by open-floor nominations, but by a plan of impersonal selection of nominees from a list of state and county officers, who, as such, are familiar with the problems of organized medicine; additional nominations from the floor also being in order. Ballots are previously prepared, containing the list of state and county officers, and with blanks for additional names. The election, therefore, takes but little time; the tellers collecting the ballots and submitting their report before the end of the meeting. The plan is mentioned for its obvious advantages, and because it may have a suggestive value to other county societies wishing to adopt, by resolution, a similar or modified plan as their own future method of procedure. The ballot sheets give the names of holdover delegates so that these are not voted upon. The full number of delegates to which the society is entitled, is voted for; the highest half so elected to act as delegates for two years, the succeeding half to act as alternates. Some of the county societies, even though they have elected their delegates for this year's session, may at this time wish to consider the plan, and then adopt it, or a modification, for use during the next and succeeding years.

From the introductory sheet of the recent Los Angeles ballot the following explanatory excerpts are taken:

> Vote for forty-one (41), the twenty (20) highest to be declared elected delegates for 1936 and 1937, the next twenty-one (21) to be declared elected alternates for 1936 and 1937.
>
> * * *
>
> The attached ballot, with nominees for delegates and alternates, was prepared in conformity with Minute No. 687, proceedings of the Board of Councilors, January 8, 1933, which provides that nominees be selected from the following groups:
>
> 1. All members of the Los Angeles County Medical Association who are members of any of the California Medical Association committees.
>
> 2. All members of the Board of Councilors not already elected to the House of Delegates.
>
> 3. All committee chairmen of the Los Angeles County Medical Association not already elected delegates.

† See page 120.

4. All alternates who have attended two State meetings.

5. All alternates who have attended one State meeting, and have given valid excuse to the secretary for their absence from the second meeting.

On the attached ballot the names of the above nominees are listed in alphabetical order for your convenience. (Additional nominations may be made from the floor.) After each name the following symbols are used to indicate from what list, in accordance with Minute No. 687, the nominee was selected.

C. M. A.—State Association Committee member.

Ch.—Chairman of a County Medical Association committee.

B. C.—Member of the Board of Councilors not now serving as delegate or alternate.

Alt.—Alternate who has attended two State meetings, or who has attended one State meeting and given valid excuse for not attending the second.

EXPULSION FROM MEMBERSHIP: RULING IN A RECENT CALIFORNIA CASE BY THE JUDICIAL COUNCIL OF THE A. M. A.

Los Angeles County Medical Association's Errors in Technical Procedures Bring Reversal of Judgment.—Some time ago, the Los Angeles County Medical Association, through its Board of Councilors, expelled from membership two of the members of that component county society. The members so expelled filed an appeal to the California Medical Association, and the Council of that Association, after several hearings in which legal proceedings were carefully observed, affirmed the action of the Los Angeles County Medical Association.

The expelled members then appealed to the Judicial Council of the American Medical Association, and at the last annual session at Atlantic City, June 10-14, 1935, that body held a hearing on the appeal. The Judicial Council's decision was received by the California Medical Association two days before the California Medical Association Council meeting of January 19, 1936, held in San Francisco, and is given in full on page 120 of this issue.

The attention of all members is called thereto and the lesson to be taken to heart: the importance of being meticulously careful in all disciplinary procedures; since the nonobservance of by-laws of the State Association on method of procedure (with which the by-laws also of component county societies must conform), may lead to the reversal of judgments on technical grounds by the higher constituted bodies in organized medicine, as in the case at issue.

* * *

California Medical Association Is Studying a New Code of Disciplinary Procedure.—The Council of the California Medical Association, through a special committee, is now studying a revised code of disciplinary procedure, which will be submitted to the House of Delegates at the Coronado annual session (May 25-28, 1936), in the belief that its adoption and use will reduce to a negligible minimum the possibilities of reversal on actions previously taken.

MEDICAL AND PUBLIC HEALTH EXHIBITS AT THE 1936 SAN DIEGO FAIR: "C. M. A. DAY" ON MAY 26

San Diego Reopens Its Fair on February 12. San Diego's Fair of 1935, through its beautiful settings and splendid exhibits made for itself a warm place in the hearts and minds of all who were fortunate enough to visit it. As a consequence, the attractive buildings in Balboa Park, instead of being demolished will be utilized for continuing the Fair in 1936, the buildings with displays being opened to visitors on February 12.

One of the structures, excellently built and located, has been set aside as the Palace of Medical Science, and in it will be placed some of the best exhibits on public health, and on preventive and curative medicine that have been shown anywhere. Members of the Association who were not able to visit the San Diego Fair last year will find in the Fair of 1936 an additional reason for attending the California Medical Association annual session at San Diego, its second meeting day, (Tuesday, May 26), having been designated as "California Medical Association Day." An announcement concerning the public health and medical exhibits which has just come to hand, gives the following additional information:

Tuesday, May 26, has been designated as California Medical Association Day at the 1936 California Pacific International Exposition, San Diego, which opens February 12 and will continue to September 9.

Approximately 3,000 physicians and their families are expected to visit the world's fair in Balboa Park upon that occasion.

Focal point of the conclave will be the Palace of Medical Science, one of the principal exhibit palaces of the 1936 exposition, where extensive displays will be sponsored by the leading medical societies and manufacturers of pharmaceutical supplies.

A program appropriate to the day is being arranged by an exposition committee of the San Diego County Medical Society, with Dr. Lyell C. Kinney, 1831 Fourth Avenue, San Diego, acting as chairman. Direct coöperation is being lent by Dr. Ben F. Eager, Medico-Dental Building, San Diego, president, and Dr. W. C. Crabtree, Medico-Dental Building, San Diego, secretary of the San Diego County Medical Society.

A medical exhibit in the Palace of Medical Science will be sponsored by the San Diego County Medical Society, with the coöperation of the California Medical Association and the American Medical Association. Dr. W. H. Geistweit, Jr., of San Diego, has been named director of medical exhibits to arrange details of this exhibit.

The committee of the San Diego County Medical Society includes Doctors Kinney (chairman), J. F. Churchill, W. W. Crawford, T. O. Burger, M. C. Harding, Alex Lesem, B. Eager, and W. C. Crabtree.

The exposition committee of the California Medical Association is composed of Doctors C. G. Toland (chairman), E. M. Pallette, W. W. Roblee, J. C. Ruddock, C. O. Tanner, Robert A. Peers, Fred Clarke, and F. C. Warnshuis.

About 1,300 square feet of space will be occupied by the American Medical Association exhibit, which will be installed under direction of a representative sent to the world's fair from Chicago.

A large space will be occupied by the Chicago Roentgen Club, and x-ray films and pathological specimens will be exhibited by the Southern California Pathologists' Association.

The California State Board of Health, in coöperation with the Hooper Foundation for Medical Research of the University of California, will be represented by a joint display.

An exhibit showing some of the work of the Board of Medical Examiners of the State of California will have a place in the building.

Los Angeles City and County Health Department will present a diphtheria prevention demonstration, and the Automobile Club of Southern California will install a safety exhibit.

Demonstrations of proper feeding of infants will be shown by the West Nursing Bureau and the Southwestern Pediatric Society, and the Pacific Coast Obstetrical Society will also participate.

Combined forces of the California Dairy Council and the Arbitration Board of the San Diego County dairy industry, under direction of Douglas Young and Wilbur Thomas, will present an exhibit, and the San Diego City and County Health Department, will coöperate under the direction of Dr. Alex Lesem, city and county health officer. Nurses, headed by Miss Ilma Lucas, nutritionist of the California Dairy Council, will act as hostesses.

In addition to the educational exhibits there will be lectures and daily presentations of motion pictures on medical subjects interesting to the general public.

The American College of Surgeons has offered to cooperate by sending speakers to the Palace of Medical Science during the exposition. During the school vacations, special motion pictures on health subjects, designed to appeal primarily to children, will be added to the programs.

Commercial displays of prominent pharmaceutical establishments and manufacturers of medical supplies also will be housed in the medical building. One of the first to be installed will be that of the General Electric X-Ray Corporation of Chicago.

It is predicted that the medical exhibits at the 1936 exposition will be the most extensive yet displayed, and will equal or surpass that at Chicago's Century of Progress expositions. The whole Palace of Medical Science will be devoted solely to exhibits treating on the prevention and treatment of disease, and it will form one of the important features of this world's fair, which is dedicated to mankind's progress in all realms of science, art, and industry.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 116.

EDITORIAL COMMENT†

DINITROPHENOL AND REDUCING

Much time has been devoted by medical science to a study of fat metabolism and to a solution of the problems concerned in the origin, pathogenesis and treatment of overweight. Practitioners of medicine are forced into daily consideration of the same problems through the frequency with which they are consulted regarding the reduction of weight. Much of their effort, however, has perforce been spent in an attempt to teach the fallacy of the many fads, "cures" and short-cuts so widely advertised for the relief of the condition. The advent of dinitrophenol, it was hoped, would do much to simplify the whole problem.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

A review of some 290 cases from the literature, in which dinitrophenol has been administered, seems to warrant several rather definite conclusions. First, the loss of weight under diet and dinitrophenol is not strikingly greater than under diet alone. Secondly, distressing symptoms are commonly attendant upon its use. Thirdly, the toxic effects of the drug upon body function and tissue cannot be denied. Fourthly, the reported deaths from dinitrophenol administration in accepted therapeutic dosages make it hard to justify its widespread application in the relatively benign condition of overweight. Let us, therefore, consider these points seriatim.

Loss of Weight. — Of the 290 patients mentioned, 276 showed loss of weight. In some instances, no loss or actual gain has been reported.[1-5] The burden of evidence shows the undoubted ability of the drug to cause loss of weight, although the mechanisms through which this is accomplished are not thoroughly understood. Bayer and Gray[1] and Strang and Evans[6] have carefully compared the rate of weight loss with and without the drug in their series of cases. The former find weight loss accelerated by the use of dinitrophenol to a greater extent than by thyroid substance. While Strang and Evans observe greater losses of weight in the cases receiving dinitrophenol than in those treated by diet alone, they feel the difference is hardly striking enough to offset the discomfort and possible damage the drug may do. Moreover, very little has been reported as to the behavior of patients subsequent to discontinuance of the drug, while still under dietary regulation.

Distressing Symptoms.—Among the distressing symptoms, one must give prominence to sensations of heat, marked sense of warmth, flushing of the skin, and profuse sweating, all of which may be looked upon as "physiologic" responses to the medication. These manifestations occurred to a greater or lesser extent in the 290 patients above mentioned. In the same groups, some type of skin condition was noted in sixty-eight individuals. This was usually an urticarial or maculopapular eruption, commonly accompanied by intense itching, and at times associated with bleb formation. Commonly reported symptoms were fever, hyperpnea, dyspnea, general malaise, tiredness, exhaustion, dizziness, faintness, headaches, and paraesthesias, at times going on to true neuritis; and pains in various parts of the body, particularly in the calves of the legs, back, and epigastrium.

1 Bayer, L. M., and Gray, H.: Obesity Treatment of Diet, Thyroid and Dinitrophenol, Am. J. M. Sc., 189:86, 1930.

2 Finkelmore, I., and Stephens, W. M.: Dinitrophenol in Dementia Praecox, J. Neurol. and Psychopath., 15:230, 1935.

3 Grant, L., and Schube, P. G.: The Effect of Alpha-dinitrophenol on Blood Cholesterol in Man, J. Lab. and Clin. Med., 20:56, 1934.

4 Masserman, Jules H.: Dinitrophenol—Its Therapeutic and Toxic Actions in Certain Types of Psychobiologic Underactivity, J. A. M. A., 102:523, 1934.

5 Tainter, M. L., Stockton, A. B., and Cutting, W. C.: Use of Dinitrophenol in Obesity and Related Conditions, J. A. M. A., 101:1472, 1933.

6 Strang, J. M., and Evans, F. A.: An Evaluation of Dinitrophenol as an Aid in Weight Reduction, J. A. M. A., 104:1957, 1935.

Less commonly observed were palpitation, anxiety, restlessness, anorexia, sore throat, delirium, and coma. Sore throat and swollen neck glands were found in two instances, with "malignant" neutropenia.

Toxic Effects.—A very good review of the toxic effects of dinitrophenol upon function and tissue has been made by MacBryde and Taussig,[7] who have added some experimental results of their own. Among their conclusions we find: "Dinitrophenol in small doses caused functional changes indicative of toxicity in liver, heart and muscles, in a large percentage of patients in whom no special idiosyncrasy was noted. It also produced a loss of dextrose tolerance." If one carefully scans the effects of dinitrophenol on carbohydrate and fat metabolism, one is led to ponder upon the probability of permanent disturbances in both function and tissue subsequent to withdrawal of the drug.

Reported Deaths.—Seven of the 290 cases, of which we have spoken, eventuated in death; of these patients five received amounts of the drug well within the recommended therapeutic dosage.

Finally, experiences with dinitrophenol should emphasize the fact that "there is no royal road to reduction." Jones[8] has well stated that people grow fat because of an excess of intake over output. It would seem that diet should still remain the fundamental keystone in the management of the overweight and obese patient: it should be supplemented by medication only as the individual case may require it.

450 Sutter Street.

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THE GENERAL PRACTITIONER AND PROSTATIC SURGERY

During the past four years volumes have been written in medical journals, and much has been written and said among the lay persons regarding the electrical, or "new" operation for enlarged prostates. Much of this literature is conflicting, and much of it is misleading, particularly that circulated among the laity. The old maxim, "a little knowledge is dangerous," is exemplified more vividly by the patients who think that they know about their illness or methods of treatment and surgical procedures. It is, therefore, not unusual to have a patient come to a physician with a preconceived idea of his ailment and the treatment indicated. With the proper explanation, the average intelligent patient can be convinced of the fallacy of his opinion, and the physician is permitted to work unhampered.

Much worse than the erroneous opinions of the patient are the erroneous ideas of the physician himself on subjects of which he can of necessity not be thoroughly informed. I refer here to the subject of the treatment of prostatic hypertrophy. The physician who does not do genito-urinary surgery is not expected to keep completely informed of the details of the developments in urologic work. As stated before, the medical literature on the subject of treatment of prostatic hypertrophy has been so voluminous and conflicting that a perusal of the same would leave one somewhat confused. It is only the person who actually does the work, and is familiar with the disadvantages as well as the advantages of the various procedures, who can properly evaluate what he reads.

Further, the present status of the treatment of prostatic hypertrophy is sufficiently flexible to allow for several acceptable and desirable surgical procedures. The particular procedure to be selected for the case under consideration is determined by several factors, namely, the patient's general condition, associated urologic pathology, type of prostatic enlargement and, even at times, the patient's social status and future requirements. In order to determine the above factors, one must necessarily do a complete urologic examination. It is, therefore, apparent that the general practitioner who originally sees the patient and makes the diagnosis of prostatic obstruction is not in a position to make final recommendations as to the procedure indicated in the particular case. When the patient is told that he has an enlarged prostate that will probably require surgery, he frequently asks if he can be treated by the "new electrical method." Many prostatic patients have heard of others who have been operated in that way and, therefore, assume that they are eligible to the same procedure in contradistinction to the "old cutting operation." The patients have an impression that this is a simple procedure, with no risk attached to it and complete cure in every case. This is true in a large percentage of cases, but is, unfortunately, not true in every case. The attending physician is prone to promise the patient this new operation and to refer him to the urologist with that in mind. When the urologist completes his examination and tells the patient that he finds the resection to be undesirable, it is then very difficult to convince the patient of the need of the "cutting operation."

It would seem permissible, therefore, to make a plea to the referring physicians to leave the matter of choice of procedure to the urologist who will do the surgery. A large per cent of prostatic hypertrophies can be properly treated by resection, so one is justified, where necessary, in telling the patient that resection will probably be the indicated procedure. Many are of the belief that the most desirable method of handling this situation is to explain to the patient that he requires a complete urologic examination in order to determine the particular type of enlargement that he has, and to see if he has any associated pathology before recommending the type of surgery to be employed.

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ORIGINAL ARTICLES

PSITTACOSIS AND TULAREMIA*

REPORT OF CASES—INFECTION OF TWO LABORATORY WORKERS IN CALIFORNIA: RECOVERY

I. REPORT OF CASE: PSITTACOSIS

A LABORATORY worker, who has for four years been intimately exposed to the virus of psittacosis in the form of infected birds belonging to various species, mice and human specimens (sputums and autopsy material), worked on October 6, 1935, with a heavy suspension of L. C. L. bodies (the elementary bodies regularly found in psittacosis) without wearing rubber gloves or face mask. The infective agent had been isolated and concentrated from the chorion-allantoic membrane of several developing chicks artificially inoculated with the virus. It was infective for mice in a dilution of 1.0 by 10^{-8}. On both October 12 and 13, 1935, he felt tired, and at 4:30 p. m. on October 14 he had a definite chill, when his temperature was 39.8 degrees centigrade. During the night a grippe-like general aching was accompanied by a severe pain in the lumbar region. Between 3 and 4 a. m. profuse perspiration gave relief and was followed by sound sleep. During the next four days the temperature invariably rose late in the afternoon to from 39.2 to 39.4 degrees centigrade, accompanied by sensations of chilliness, and then fell to 37 degrees after midnight, followed by perspiration. There was no headache and the night sleep of from six to eight hours was sound, free from dreams, and refreshing. The pulse varied between 76-88 and the respiration was from 10 to 20. Despite the loss of fluid during the attacks of perspiration, thirst was in no way pronounced. There was a moderate anorexia, however, and the digestion and stool were normal. A chronic bronchitis of several months' standing subsided during the first three days of the acute illness, and the absence of coughing or pharyngeal irritation was noteworthy. The nasal mucus, forcibly expelled, was slightly tinged with blood. There was no herpes labialis. On October 16, 1935, the blood examination revealed: hemoglobin, 102; red blood cells, 5,740,000; white blood cells, 5,950; granulocytes, 85 per cent; lymphocytes, 9 per cent; and mononuclears, 6 per cent. Dr. Herbert C. Moffitt examined the patient on October 16 and subsequent days, and recorded the following findings:

"Interesting points in the history were recent laboratory exposures to both psittacosis and tularemia, and a well-known immunity to all forms of Brucella infection. An associate† in the early October work had just entered the University Hospital with high temperature and indefinite pulmonary signs. There was no repetition of the initial chill, although temperature rose rapidly each afternoon for four days. Sweating was profuse for four or five nights, and was followed by rapid drop in temperature and complete relief of malaise and lumbar backache, which was severe for two days. No eruption was seen in mouth or on skin. A cough of three months ceased abruptly with onset of chill and high temperature. On October 21, for the first time tympany was noted over the right back, just inside and below the scapular angle. Cough and deep inspiration caused an explosion of fine crepitant râles, which we have learned to associate with a pneumonic process, beginning in the lower lobe near the hilus and gradually extending toward the periphery. These signs completely disappeared after three days."

Since the pulmonary signs located on October 21 were not followed by coughing, two (one gram) doses of ammonium chlorid were administered. During two coughing spells, a coffeespoonful of brownish-tinged, slightly mucoid sputum was raised on October 22, 1935. Microscopically, it showed streptococci, small and large Gram-negative rods, few Spirochaetes and fusiform organisms. A mouse test for pneumococci was negative. On the blood plates alpha streptococci, influenza and Friedlander's bacilli developed. A broth extract of the sputum inoculated intraperitoneally into mice and a ricebird gave the following results:

Mouse 19382 died on third day. Indefinite lesions.

Mouse 19383 died on seventh day. Typical gross lesions of psittacosis, with L. C. L. findings.

Mouse 19384 killed on ninth day in extremis. Typical lesions. Virus repeatedly passaged through mice and one ricebird.

Mouse 19385 killed on eleventh day. Slight lesions.

Ricebird 476 killed while ill on eleventh day. Slight lesions. Virus passaged.

A second specimen of sputum, definitely blood-tinged, collected on October 24, 1935, at a time when the daily temperature varied between 36.2 and 37 degrees centigrade, presented the same flora. The mouse test for virus was as follows:

Mouse 19390 died on tenth day. Inconclusive, due to spontaneous renal abscess.

Mouse 19391 killed on nineteenth day. Medium-sized spleen.

Mouse 19392 killed on thirty-sixth day. Large spleen, liver necrosis. Splenic suspension, when passaged, fatal to mice in five days.

Mouse 19393 killed on thirty-sixth day. Medium-sized spleen.

Despite the use of ammonium chlorid, no further sputum specimens could be procured. The blood serum collected on November 5, 1935, gave negative agglutination tests with the enteric fever antigens, B. tularense, Brucella abortus and melitensis. The complement fixation test for Brucella abortus was positive in a dilution of 0.05 (the patient is immune to the Brucella types, gives a strong allergic skin test and a phagocytic index of 30). Convalescence was decidedly slow. A general weakness foreign to the patient persisted for weeks. An x-ray film taken on November 14 showed a very faint, hazy density in the lower right lobe.

COMMENT

The observation proves again the customary saying, familiarity breeds contempt, and the general belief that continuous exposures to the virus of psittacosis may lead to a latent immunizing infection is rudely contradicted. In retrospect, it is by no means difficult to trace the disease directly to the careless handling of virus-containing material, which is in all probability far more infectious than the average bird or mice specimens. Darkfield examinations, diverse staining procedures, and the preparation of serial dilutions lend themselves to contamination of the unprotected hands. Furthermore, it is not unlikely that the virus enriched on the chick embryo may acquire new invasive properties. A German bacteriologist, who contracted psittacosis in the ten months of his intensive study of the disease, states that he contracted the infection while passaging the virus through the chicken egg.

The influenza-like character of the attack without headache would have escaped etiologic identification without the examination of the sputum. In fact, this experience lends considerable support to the belief that the mild grippe-like minor illnesses which develop in the occupational groups or households exposed to infected psittacine birds are rudimentary attacks of psittacosis. One naturally would like to know if such an attack leaves an immunity of some sort. Neutralizing antibodies, despite a severe disease, are frequently not

* Editor's Note.—The case histories here reported are those of two well-known laboratory workers in California, who were infected, respectively, with psittacosis and tularemia. Out of courtesy, names are omitted.

† See report of case of tularemia which follows as Part II of this article.

demonstrable. The complement-fixation test with the usual mouse-spleen antigen is not very dependable. Perhaps tests with purified elementary bodies may yield more definite information. Finally, one should keep in mind the possibility that the virus which exhibits such a remarkable tendency to latency may remain unrecognized in the body, but may through an intercurrent infection become mobilized. It is, doubtless, unwise to place implicit confidence in the belief that "silent," or even recognized virus infections confer a permanent protection. One must, therefore, continue to maintain appropriate precautionary measures and continuous vigilance against laboratory infections.

II. REPORT OF CASE: TULAREMIA

A case of tularemia is reported which is of interest as an infrequent type of involvement, and because of the diagnostic problem presented.

The patient, a laboratory technician in research bacteriology, was first seen on October 15, at which time she gave the following history:

Present Illness.—For the past two and one-half years she has been working with psittacosis and relapsing fever material, and for three weeks prior to onset of her illness her duties had also included the handling of material from tularemia cases. She does not recall any break in technique, pricks of hands or defective apparatus, and has always worn rubber gloves when working with infectious material. It is not unlikely that the pipetting of an uncompletely sterilized suspension of B. tularense on October 7, 1935, furnished the source of infection.

On October 10, the patient had some headache and felt unusually tired. She felt improved the following morning and went to work as usual. In the evening she felt feverish and had general aching, temperature 100.8 degrees Fahrenheit. During the night she perspired rather freely, and again felt sufficiently improved to report at the laboratory the morning of October 12. Had no appetite at noon, and left work in mid-afternoon because of extreme fatigue. Headache returned and temperature rose to 101.6 at 10 p. m. Remained in bed on Sunday, October 13, and Monday, October 14; generalized aching persisting, and with headache increasingly severe and throbbing in character. Temperature rose to a maximum of 102, and transient nausea was noted as well as suboccipital pain and slight neck stiffness.

Illness was reported on October 14, and the patient was brought into the hospital the following morning, at which time she complained of constant, severe headache, generalized, general aching, some photophobia and mental dullness. She stated there had been no chills, cough, sore throat or other respiratory symptoms. No adenopathy, no rash; bowels somewhat sluggish since onset of symptoms.

Family History and Past History.—Not significant.

Physical Examination.—Negative for cause of symptoms; no adenopathy.

Laboratory Findings.—Urine, negative; white blood cells, 7,840; polymorphonuclears, 73 per cent; agglutination positive, 1-20—typhoid and paratyphoid A and B and Brucella abortus; phagocytic index, 3.8; complement fixation Brucella, negative.

X-Ray.—Chest showed heavy root shadows, especially on right, and peribronchial infiltration extending from lower hilum on right to an area of consolidation six centimeters in diameter in upper portion of right lobe.

Physical, laboratory, and x-ray findings continued unchanged for the ensuing five days (except that no further agglutination with Brucella abortus was obtained); temperature meanwhile showing wide swings between normal and 104 degrees Fahrenheit. Subjectively continued to have troublesome headaches and slight nausea, but there were no symptoms referable to the lungs. Marked drops in temperature were associated with rather profuse diaphoresis.

October 21: The white blood corpuscle count rose to 12,750, 69 per cent polymorphonuclears; phagocytic index for Brucella, 16.36.

October 22: White blood corpuscle count was 14,350, 61 per cent polymorphonuclears. Chest examination on this date for the first time revealed moderately fine, moist râles over an area 8 to 10 centimeters in diameter on the right side posteriorly, corresponding in location to consolidation shown in x-rays of October 15 and 18, but apparently larger in extent.

October 23: Chest film showed extension of the consolidation outward and downward, with appearance of softening in the original area; blood count, 13,980; polymorphonuclears, 73 per cent.

October 24: Physical examination revealed dullness and suppressed breath sounds below the original involvement, and râles heard over a wider area than at preceding examinations.

Repeated agglutinations and blood cultures were negative during this interval, except for the above-mentioned positive agglutination in low titer, explained by past and anti-typhoid inoculation. Fever continued high; there was very slight, dry cough; and after administration of ammonium chlorid, a small amount of watery sputum, apparently mainly saliva, was obtained and injected into mice and cultured. Culture showed alpha-streptococcus, Staphylococcus aureus, m. catarrhalis, and Friedlander's bacillus.

Pulmonary involvement with slight leukocytosis, fever and headache, were suggestive of psittacosis in absence of laboratory evidence in favor of other etiology. Increasing involvement and falling white count was considered as indications of low resistance on the part of the patient, and it was deemed desirable to assume the probable etiology as psittacosis and administer convalescent serum. Twenty-five cubic centimeters of a pooled serum obtained from two recovered psittacosis patients was given on October 25, and repeated on the following day. It should be noted that one of the donors had also survived a tularemia infection.

Prompt subjective improvement was noted, and a decided drop in temperature followed the serum administration, with no subsequent rise above 100 degrees Fahrenheit.

Diagnosis was made by:

1. Agglutination test, positive, October 28 for B. tularense 1-640—4 plus, 1-1280—2 plus. November 5, for B. tularense 1-1280—4 plus.

2. Skin test October 28, which was positive October 30, with area of reaction 37 mm., central induration 8 mm.

3. Confirmed by recovery of organism B. tularense, identified by agglutination, from lesions in mice dying five to eight days following injection with sputum obtained from patient on October 25. This organism, passed into guinea-pigs, produced typical lesions of tularemia.

Progressive improvement in general condition, physical findings and x-ray evidence have been noted. Convalescence has been slow, strength returning with the reluctance characteristic of B. tularense infections. X-rays still show considerable thickening and suggest the probability of residual fibrosis, although to date each successive film has showed some improvement.

COMMENT

Of special interest is the absence of cutaneous and lymph-gland lesions and the limitation of involvement to the lungs. Presumably, infection took place by way of the respiratory tract, and the location of the lung involvement would suggest primary localization in the bronchial lymph nodes with extension from them into the lung parenchyma. Lack of positive agglutinations up to the eighteenth day, and a high phagocytic index for the Brucella organism on the eleventh day of the disease, added considerably to the problem of diagnosis.

POISONING DUE TO THE INGESTION OF A MIXTURE OF SODIUM BICARBONATE-SODIUM FLUORID*

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DURING the late afternoon hours of Monday, November 18, 1935, P, aged eighty-seven years, was admitted to the San Francisco Hospital seriously ill, after having taken baking soda some six or eight hours previously. In placing a "hurry call" for the ambulance, a neighbor furnished the information that the man's daughter, S, aged fifty-three years, had died within the hour, of what appeared to be some form of poisoning. With only these meager data in hand, an investigation was initiated.

REPORT OF CASES

CASE 1.—From the patient, P, it was learned that he had eaten dinner on Sunday, November 17, 1935, with his daughter, S, and other members of the family. The foods served included: roast turkey, dressing, carrots, spinach, applesauce, celery, bread and butter, gingersnaps, and pumpkin pie (all fresh foods). None of those present at the dinner were ill other than P and S. P returned to his home about four o'clock that same afternoon, and retired later without taking other food or drink. On arising at nine o'clock Monday morning, November 18, 1935, and before drinking a cup of chocolate, he prepared and took "half a teaspoonful of baking soda in half a glass of water." The baking soda was part of a quantity given him by his daughter, S, the day before, in a paper bag, as part of a two-pound package purchased by her, in bulk, on Saturday, November 16, 1935. According to the patient's own story, as given to members of the resident staff of the San Francisco Hospital, he vomited about noon, had severe pain over the chest, perspired freely, had diarrhea, experienced a continued taste of the soda, had loss of power in the extremities, and finally collapsed.

The patient's private attending physician was called about three o'clock in the afternoon, and was furnished the information that the elderly man had "had a stroke." On examination, he found the patient unconscious and in a serious condition, with a foamy exudate blown from the anterior nares, "at a rate of about an inch every four or five seconds." In his rapid and necessarily cursory examination, the physician found: evidence of vomiting (the vomitus was liquid, containing no solid material at all), no diarrhea, the eyes reacted to light, while the throat was dry and there was a definite wrist drop ("radial palsy"). Immediate hospitalization was recommended and arrangements initiated. After a fifteen-minute wait for the ambulance, a second call was placed by a neighbor, and the man removed by ambulance to the San Francisco Hospital.

On admission to the San Francisco Hospital the patient was cyanotic, stuporous, but responsive to questioning, and presented the picture of an acute illness involving, perhaps, the respiratory tract, the gastro-intestinal tract, the cardiovascular system, and the central nervous system. During the examination made by members of the resident staff of the hospital, he suddenly died, within twelve hours after having taken the soda.

* * *

CASE 2.—From the private physician and the patient's daughter, it was learned that S, also, first used the soda on arising early Monday morning, November 18, 1935. She, also, had retired Sunday evening without taking other food or drink, following the dinner of that afternoon. She was accustomed to taking half a teaspoonful of soda on arising, apparently, usually about 6:30 o'clock. A few minutes after taking the soda she remarked to her daughter that "that soda made me sick," whereupon she vomited violently. This was followed shortly after by profuse perspiration, severe diarrhea, cold extremities, cramps in the legs, urticaria over the neck and trunk, and, finally, prostration. She was put to bed and treated by her physician as having a severe form of "food poisoning." She slept awhile and seemed better for a time, but quickly became worse in the early afternoon and died about three o'clock.

The soda used by S was from the same lot as that purchased by her on Saturday, November 16, 1935, and of which she gave a quantity to her father, P, on Sunday, November 17, 1935. None of the other members of the family were ill, and they, likewise, did not take any of the soda. Samples from the package submitted as being the soda originally purchased by S, on qualitative chemical study, showed definite evidence of arsenic and relatively large amounts of fluorin. Quantitative analysis later showed the arsenic content approximate fifty parts per million and the sodium fluorid to approximate 60 per cent, with sodium bicarbonate but 40 per cent of the total sample. Additional packages, obtained by inspectors from the Department of Public Health on Tuesday, November 19, 1935, from the same source as the package purchased by S, were studied in the laboratory, and their contents, on qualitative analysis, showed both fluorin and arsenic to be present, and on quantitative analysis, checked closely with the sample referred to above.

* * *

CASE 3.—It was learned on Tuesday, November 19, 1935, that O, aged sixty-one years, had died on Thursday, November 7, 1935, under circumstances which indicated that sodium bicarbonate might have been the responsible factor and the cause of death. It was subsequently learned that she had taken part of a teaspoonful in water, with a woman friend, on the evening of Wednesday, November 6, 1935, presumably to relieve gastric distress following a meal. Her friend induced vomiting, saying that "the soda did not taste right," but O was not unfavorably impressed by the taste of the soda. She was found dead in her home the following day, Thursday, November 7, 1935. The soda taken by O was obtained from the same source as that used by P and S.

CORONER'S FINDINGS

These three cases were all considered at the same coroner's inquest.

Toxicologic and Pathologic Reports.—These may be briefly summarized:

In the case of O, the coroner's toxicologist reported that fluorin and arsenic were easily demonstrable in the stomach and contents, and in the "baking soda" as well.

In the case of S, fluorin and arsenic were not demonstrated in the stomach and contents; and in the specimen of sodium bicarbonate studied, fluorin was present and the presence of arsenic, while not demonstrated by the Reinsch test, was demonstrable by the Gutzeit test. In the case of S, the positive significant gross changes involved a yellow liver with evidence of cloudy swelling of the cells, with microscopic changes showing toxic degenerative changes (cloudy swelling) of heart muscle, liver cells, the epithelium lining the tubules of the kidney and acute hemorrhagic congestion of the lungs, all interpreted as evidence of protoplasmic poisoning.

In the case of P, the sodium bicarbonate involved was the same as that in the case of S, and the stomach and contents were negative for fluorin and arsenic. The pathologic findings in P, while less marked than in S, were essentially the same (except for evidence of heart disease with coronary sclerosis, as one might expect in a subject of the ninth decade of life), with evidence of a protoplasmic poison having resulted in

* From the Department of Public Health, city and county of San Francisco.

toxic degeneration of the liver. The coroner's jury, on the basis of the evidence submitted, found that "P, S, and O had come to their deaths after using baking soda with a mixture of sodium fluorid. . . ."

OTHER CASES REPORTED TO THE DEPARTMENT

Concurrent with the investigation into the circumstances surrounding the deaths, during which time the findings were given full and complete publicity in the newspapers and through radio broadcast, eighteen cases of non-fatal poisoning, traceable also in all instances to the sodium bicarbonate-sodium fluorid mixture purchased later than October 23, 1935, were reported to the Department. In these instances the bicarbonate-fluorid mixture, used to the extent of one teaspoonful to a quantity of pancake batter sufficient to make pancakes for a family of two adults and six children, produced symptoms and signs of severe gastro-intestinal irritation with vomiting, abdominal cramps and diarrhea, consistently in all those who ate of the pancakes. The maximum dose taken, in any instance, was one teaspoonful in a glass of water. In those instances in which the packages of baking soda were available for laboratory study, qualitative analysis showed the presence of fluorin and arsenic, and quantitative analysis showed varying amounts of both up to 74 per cent sodium fluorid, forty-four parts per million of arsenic, and no sodium bicarbonate. Inasmuch as the various samples studied, all from the same general source, gave varying results on study by the same methods of analysis, one is forced to be impressed by the "spotty" or "pocket" distribution or lack of homogeneity of the mixture.

HOW SHALL THE INSECTICIDE PROBLEM BE SOLVED?

The experience described in this paper has two major aspects: The local problem, with particular respect to the appropriate rigid supervision of persons, firms and corporations dealing in food and drugs, of greater importance in a port city or in a railway terminal city, but a problem which may exist in any city, should be met through suitable legal instruments giving effective authority to the local health official or to the proper state agency, provided that agency is equipped, financed and staffed sufficiently well to cope with the problem, to the end that such appropriate rigid supervision of such dealers may obtain. As we see it, however, the greater and more important aspect involves the whole problem of insecticides, their labeling, distribution, sale and use, and the increasingly important relation of spray residue on foodstuffs, particularly fruits and vegetables, to the personal and public health.

It should not be necessary to point out that fluorids and arsenates are being more widely used in agriculture today than ever before; that in certain areas the content of arsenic in the soil is so great, from spraying, that the agricultural products grown in the area contain significant quantities of arsenic; that present legislation and regulations do not require the labeling of fluorin and arsenic-containing insecticide compounds as poisonous; that insecticides are all too frequently shipped, transported, distributed, sold and used in close association with food and drugs, in the home, the store, the warehouse, on the farm, in the food factory and elsewhere.

Knowing these facts, the question is not, "How do poisonings, such as that herein reported, occur?" but rather, "Why do such poisonings not occur with greater frequency?" Any answer to this problem necessarily involves consideration of the possibility of the occurrence of mild affections unrecognized as caused by the ingestion of small quantities of fluorids, arsenates, or other insecticides or other poisonous compounds which may have been present on foodstuffs. Chemical types of "food poisoning," certainly less frequent during past years than bacterial or bacterial-formed toxic products types, are not to be forgotten in medical practice.

SODIUM FLUORID AS A TOXIC AGENT

Sodium fluorid has been widely advertised as non-toxic for the human, and as a constituent of ant powders the only warning given frequently has been "Keep away from children," implying by inference, perhaps, that it is safe for adults. In the eighteen non-fatal cases reported to the department during the course of the investigation herein reported, adults and children were affected. The quantities of the sodium bicarbonate-sodium fluorid-arsenic mixtures ingested varied from that quantity contained in a few pancakes made from batter sufficient for a family of seven, and in which but one teaspoonful was used for the entire batch of batter, up to one teaspoonful in water. It is but one step further to point out the possibilities offered by sodium fluorid on vegetables, as ant powder or other insecticide; for many ranchers or farmers are of the opinion "if a little of the spray is good, a lot ought to be better." The toxic properties and effects for the human, adult as well as child, of the doses cited, namely, a teaspoonful or less of the mixtures of bicarbonate-fluorid, should be carefully noted and considered by all thoughtful physicians and health officers.

THE ARSENIC COMPLICATION

The presence of arsenic was not entirely satisfactorily explained except that it might have been a contaminant of the commercial sodium fluorid in its manufacture. The possibility of any quantity of arsenic in the commercial product in excess of one part per million was practically denied by the manufacturers of the product involved, and the possibility itself has been both affirmed and denied by official medical and Federal Government authorities. Confusion to the entire epidemiologic study was contributed by the results of the chemical analysis done in the laboratories of the department, since, presumably because of the heterogeneous mixture with "spotty" distribution of the compounds, varying results, both qualitatively and quantitatively, were obtained in small samples of the same specimen one-pound package being investigated. Likewise, it would appear to be true that the presence of fluorids in the material tested

affects the results of the ordinary standard tests for arsenic when the tests are carried out, as usual, in ordinary glass containers.

In the Gutzeit test, for example, hydrochloric or sulphuric acid, in reacting with the sodium fluorid mixture permits of the formation of hydrofluoric acid, which, in turn, attacks the wall of the glass container, dissolving sufficient quantities of the glass to permit of positive reactions for arsenic from the arsenic contained in the glass itself. Of course, with a prolongation of the time interval beyond the two-hour period ordinarily followed in standard procedure, the results obtained would indicate greater quantities of arsenic, for obvious reasons. Recheck analyses, in which the reactions were carried out in paraffin-lined containers, gave consistently negative results for arsenic. The only logical conclusion that can be drawn, therefore, as to the source of the arsenic in the mixture (as revealed in the laboratory studies executed during the field investigation by the Department of Public Health, the Coroner's Office, and the Food and Drug Administration of the United States Department of Agriculture) must consider that the varying quantities of arsenic found came, not from the mixture of sodium bicarbonate and sodium fluorid or commercial sodium fluorid, but from the glass containers in which the tests were carried out. It should be emphasized also that the time interval used in the test, as well as the quality of the glass containers themselves, are of considerable import in this respect.

SUMMARY

1. A mixture of sodium bicarbonate and sodium fluorid, sold in bulk as sodium bicarbonate or baking soda, was responsible for poisoning in twenty-one reported instances, three of which terminated in death.

2. Samples submitted by those made ill and by members of the families of the deceased, and those obtained by the inspectors of the Department of Public Health from the various sources involved (except those from intact barrels of the original product) consistently showed arsenic and fluorin on qualitative chemical analysis; on quantitative analysis these same samples were found to contain varying proportions of sodium bicarbonate and sodium fluorid, demonstrating a heterogeneous, "spotty," or "pocket" distribution.

3. The epidemiologic picture, at first confused by the positive reactions indicating the presence of arsenic in the specimens of "baking soda" (sodium bicarbonate-sodium fluorid mixtures) and of commercial sodium fluorid, was clarified through further study, which brought out the fact that hydrofluoric acid, found through the reaction of hydrochloric or sulphuric acid with the sodium fluorid of the mixture, dissolved the glass of the containers and released arsenic therefrom in sufficient quantities to give positive reactions for arsenic. Recheck tests in paraffin-lined glass containers gave consistently negative results for arsenic.[1]

4. It should be emphasized that there is no danger from sodium bicarbonate of standard brands, sold in good condition, in the original package.

5. The incident should awaken interest in the real and potential hazards existing in the salvage of foods and drugs, and the need for effective legislation which will require and provide adequate official supervision and regulation over all persons, firms and corporations dealing in foods and drugs.

6. This incident, as also those reported by Simpson and his coworkers,[2] should serve as a warning and give impetus to the medical profession as well as local, state and federal authorities and officials, to secure adequate control over the labeling, manufacture, distribution, sale and use of insecticides, particularly those containing fluorin.

IN CONCLUSION

Fluorid poisoning, as a result of the ingestion of quantities smaller than those heretofore considered toxic for humans, is a very real hazard to the public health, even as a cause of death, in addition to the effects of the mottling of teeth, as reported from Arizona and other points,[3] and gastro-intestinal irritation. The control of traffic in insecticides should receive attention as a medical problem, rather than simply an agricultural and entomologic problem, affecting the personal and public health.

101 Grove Street.

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ACUTE FLUORIN POISONING*

WITH REPORT OF FIVE CASES

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San Francisco

DISCUSSION *by P. J. Hanzlik, M.D., San Francisco; C. D. Leake, Ph.D., San Francisco.*

OCCASIONALLY, in any year, a city the size of San Francisco is turned into a biological experimental laboratory by an unfortunate accident. The tragic residue of such misfortune accumulates in the civil courts of the city, while the scientific data is collected and compiled at the city morgue. As the result of a recent unfortunate circumstance in San Francisco, three deaths were recorded from the ingestion of almost pure sodium fluorid, and we wish to add to these three two more deaths which resulted from the voluntary ingestion of fluorid-containing insecticides with suicidal intent. All of these cases show consistent and similar anatomical changes which substantiate pathologic findings reported by others. They have an additional interest, however, in that they contribute to the knowledge of the mini-

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mum lethal dose of fluorid which will kill human individuals. It has been known for some years that reasonably small amounts of sodium fluorid or sodium fluorosilicate would cause death, and Marcovitch,[1] in 1928, discussed the acute toxicity of sodium fluorosilicate, reporting a fatal case where only half a teaspoonful of the substance had been ingested. Fatalities from less sodium fluorid than this are not available in the literature, but deaths from the substance have been reported by Sommelet,[2] Kockel and Zommerman,[3] Hickey,[4] McNally,[5] and Luhrig,[6] whose second patient had taken one-half teaspoonful of insecticide containing 99.6 per cent sodium fluorosilicate, while McNally reports death from ingestion of 4.5 to 5 grams of sodium fluorid. Much smaller doses than this, of course, will cause acute toxicity without death, and Kolipinski,[7] in 1866, pointed out that in human individuals any amount of sodium fluorid in excess of one-fourth grain (0.016 gram) is liable to cause nausea. Baldwin[8] reported that a quarter of a gram by mouth would cause nausea in two minutes, and Vallée,[9] in 1920, reported seven cases of poisoning by sodium fluorid where the amounts absorbed were reported as from 0.228 gram to 0.45 gram. Other reports seem to establish that the minimum toxic dose is somewhere around 0.05 of a gram, with the symptoms of gastralgia, nausea, vomiting, convulsions, paralysis of the motor center and salivation increasing to the minimum lethal dose, and that death would occur after the ingestion of four grams or perhaps a little less. The information on animals is somewhat more accurate. In 1867, Rubuteau[10] published data showing that when 0.5 of a gram was given to dogs by mouth, symptoms were produced, but he found that 0.25 of a gram by mouth produced no demonstrable changes. One gram intravenously caused serious symptoms, but was not fatal. In rabbits, 0.25 of a gram by mouth caused symptoms, and the same amount injected intravenously proved to be fatal. In 1894, Haidenhain[11] reported the fatal dose of fluorid for a dog to be 0.05 to 0.1 of a gram per kilogram of body weight when given intravenously. And Leake,[12] corroborating this finding, reported 87.5 milligrams per kilogram to be the minimum fatal dose intravenously in rabbits. Death occurred about forty minutes after injection of the minimum fatal dose. In continuing this work, Muehlberger,[13] in 1930, tested other fluorid salts than sodium fluorid, but with essentially the same findings. The symptoms he observed were salivation, diarrhea, tremor and, at times, terminal clonic and tonic convulsions. Animals receiving barely lethal or slightly smaller doses showed a persistent cachexia, and albuminuria was frequently present. In rabbits killed by sodium fluorid, the pathologic changes he noted were limited to the liver and kidney, the liver showing some congestion and hydropic degeneration, as well as some fatty changes in the cells. Schultz[14] found that lethal doses in experimental animals acted on the central nervous system, as well as upon the stomach and blood, producing a paralysis of the cord and brain, ending in stiffness, numbness, salivation, and gastric hemorrhage. The whole subject, in both acute and chronic forms, is presented in the excellent review of De Eds.[15]

In the first group of three cases to be reported, fluorid was taken in the form of sodium fluorid after being mistakenly sold for sodium bicarbonate and ingested with the same impression persisting. As far as can be determined, approximately half a teaspoonful, or three to four grams, was taken in these cases, with death following in from six and one-half to twelve hours.

REPORT OF CASES

1. *Accidental Poisoning Group*

CASE 1.—Mrs. C. O., white, sixty.

At eight o'clock p. m. the subject was visiting a friend who had some gastric disturbance and suggested that she take a little soda for relief. The friend acquiesced, and took one-half of one teaspoonful (three grams) in water. Although feeling perfectly well, Mrs. O. also took half a teaspoonful (three grams) in water, to be sociable. They both noted an odd, rather bitter taste, and a few moments later both were nauseated. The friend immediately vomited her entire gastric content. Vomiting was attempted by Mrs. O., but was fruitless. There was a rather rapid prostration, a feverish feeling, and in fifteen minutes a diarrhea. Severe oral burning ensued and the tongue was sore. She remained with her friend, who had been able to vomit repeatedly, until midnight, when she went home. At this time, approximately four hours after ingestion, she was very weak, nauseated, and having a premonition of death requested an autopsy in the event of her demise. Her brother gave her some hot water and then retired. She died unobserved at approximately 2:30 o'clock the following morning, six and one-half hours after the initial symptoms and ingestion. The autopsy findings were consistent with the composite report, which follows. Chemical analysis showed fluorid and a trace of arsenic in the stomach, liver, and kidneys. Analysis of the material ingested showed 99 per cent pure sodium fluorid, and 250 parts per million of arsenic, the latter being regarded as a commercial impurity. Subsequent studies show the arsenic to have been dissolved out of pyrex glass of the container by the etching action of sodium fluorid solution.

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CASE 2.—Mrs. B. S., white, fifty-three.

It was the subject's custom to take a little baking soda twice a week in water shortly after arising in the morning. At 7 a. m., the day of her death, she entered the kitchen shortly after dressing and took one-half of one teaspoonful of a substance which she had purchased in bulk the previous day, and supposed was baking soda. Her husband found her a few moments later sitting in a chair with perspiration beginning to appear on her forehead. She remarked immediately: "Leave that baking soda alone—it is poison." Inside of ten minutes there was extreme nausea and vomiting, with diarrhea following about fifteen minutes after ingestion. A doctor was summoned and arrived approximately twenty-five minutes after the material was taken. He found the patient pulseless and prostrated. She was put to bed, still vomiting, and was given hot water each time emesis occurred. The type of poison was not known and no antidote was given. There was no abdominal pain. In approximately an hour she was semi-comatose and began to have successive chills. Hot-water bags were placed about her, following which she relapsed into coma again, from which she would awake, vomiting. She grew progressively weaker and had a constant premonition of death. At 2 p. m. she felt cramps in her legs and had some clonic spasms. She was given an alcohol rub, which eased her somewhat. About 2:30 p. m. her whole body broke out in a rash. Weakness was increasing. She had a feeling that she was burning up inside. She begged for water, which was administered, and attempted to vomit at this time, but was unable to raise any fluid. The patient was extremely weakened

and muscular contraction was difficult. She was semiconscious, however, and able to converse with her daughter. At 3 p. m., eight hours after ingestion of the poison, she died, apparently from a respiratory paralysis. The autopsy findings in this case were consistent with those which are subsequently described. Fluorid was not recovered from either her stomach or viscera. The material ingested was 84.5 per cent sodium fluorid.

* * *

CASE 3.—Mr. A. T., age eighty-six. Retired carpenter. Father of Mrs. S., Case 2.

The patient was found in bed about 2 p. m. by neighbors, who immediately summoned a doctor. Examination showed him to be salivating, frothing at the mouth and nose, practically pulseless, cold and comatose. He was transferred to the Central Emergency Hospital. By emesis in the sink, it was concluded that he had been vomiting. Because of this the stomach was not lavaged at the Emergency Hospital, but the patient was put to bed and kept warm. He improved, and at approximately five o'clock in the evening was able to talk. He gave a history of having eaten a large dinner the day before and, feeling distressed that evening, had taken baking soda. The following morning, upon awakening at seven o'clock, he felt sick and nauseated, and took approximately one-half teaspoonful more in water, the soda having been part of the package his daughter Mrs. S. purchased the previous day. This made him acutely ill and he vomited a number of times, which was followed by diarrhea. The vomiting and diarrhea continued the better part of the day. Later in the afternoon he noticed that his hands were growing weak and gradually becoming paralyzed. He felt very weak and had some pain across the lower part of his chest. Froth, which had been found exuding from his nose when first visited by his doctor, had disappeared, and at 5:30 p. m. his temperature was normal, blood pressure was normal, and pulse was 85. His hands and arms were paralyzed and there was some weakness of the lower limbs. He grew gradually weaker and died at 7:20 p. m. that day, approximately twelve hours after ingestion of the poison. Toxicologic examination of the stomach was negative for fluorid, and the presumption is that he had completely evacuated the substance by vomiting.

COMMENT

The clinical similarity of these cases is apparent, the only variation being rapidity of death after ingestion. The shortened interval in the first instance, we believe, is due to the inability to evacuate the stomach by vomiting, and this is substantiated to a great extent by the finding of fluorid in the stomach of the first individual, and by its absence in the stomach of the other two.

2. *Suicidal Poisoning Group*

The second group of two cases were the results of voluntary suicidal ingestion and, while no histories are, of course, available, it appears by the amount of insecticide remaining in either can that something less than an ounce of the material was taken. Both individuals were found dead in the morning, having died during the preceding night. Fluorid was recovered from the stomach in both instances.

PATHOLOGIC FINDINGS

The pathologic changes in all cases are consistent, and will be reported as a composite picture. Upon the initial incision one is struck by the extraordinary congestion and hemorrhagic infiltration of all of the organs, but particularly of the spleen and lungs. Throughout the pulmonary parenchyma, there is a dilatation of the vessels and congestion of the vascular channels, and blood oozes from the alveoli as the tissue is cut. Because of this infiltration the lungs are increased in weight, but they show no focal areas of necrosis or other damage. The heart varies with age and physical influences, but shows, in addition, a moderate dilatation, loss of muscle tone, and a congestion of the vascular beds. The liver is quite yellow, but the edges are sharp and the color is uniform. There are no areas of necrosis or acute damage, but on section there is a cloudy swelling apparent throughout. The spleen is enlarged, acutely congested and engorged with erythrocytes. The lymphoid elements are not prominent. The pancreas appears grossly normal, but the kidneys show an acute congestion, are rather edematous and moderately swollen. The reproductive organs in both male and female show no pathologic changes. In the gastro-intestinal tract there is an acute congestion, and hyperemia of the gastric mucosa, as well as similar changes to a lesser degree in the rest of the bowel. There are small points of hemorrhage in the gastric mucosa, and the stomach contains blood-stained fluid.

Microscopic sections show an edema of the heart muscle, with some separation of the fibers and a little cloudy swelling of the cytoplasm. There is a general congestion of the circulatory channels, but no apparent endothelial damage. The lungs show the diffuse congestion described grossly with cells packed densely into the capillaries of the alveolar walls, and with fresh hemorrhage in the alveolar spaces. There is no acute focal necrosis and no evidence of inflammation other than the acute congestion. The liver shows a moderate fatty infiltration of the cells, with large droplets in the cytoplasm. The cytoplasm, in addition, is quite cloudy, and the cells are swollen. There is no degeneration or breaking up of the nuclei, however, and no changes about the portal areas. The spleen is congested with erythrocytes and the sinusoids are packed full of these cells. There is no apparent change in the white cell element, while the pulp and corpuscles are normal excepting for a moderate edema. The acinar cords of the pancreas are normal and the islets show no changes. The glomerular tufts of the kidneys are congested, and the capillary channels filled with erythrocytes. The glomerular capsules are clean, however, and the capsular spaces contain no exudate. There is a general cloudy swelling of the cells lining the tubules. The sections of the genital system are normal. Sections of the gastro-intestinal tract show an acute hyperemia and congestion of the circulatory channels. There is a little blood on the surface of the mucosa, and some of the mucosal cells are cloudy and beginning to degenerate. Changes in the central nervous system are limited to edema and a congestion of the vascular channels.

COMMENT

These findings are consistent with the pathologic observations in the previous cases of fluorid poisoning which have been reported by others. The clinical symptoms, too, substantiate published reports excepting the rash which appeared currently in Case 2. This, we feel, was not a toxic rash, as has been suggested, but a multiplicity of petechial hemorrhages following the chemical action of the fluorid ingested. As Kobert suggests in his "Lehrbuch der Intoxikationen," the

coagulation of the blood is abolished because of the binding of the calcium with fluorin, forming the insoluble calcium salt. While this exact mechanism may be subject to some question, there is no question that sodium fluorid is an active and efficient anti-coagulant, and such a property was probably operative in the individual. The hemorrhages were the same cutaneous petechial type that one would see in any other hemorrhagic diathesis, whether chemical or due to physiologic changes in the preformed clotting elements of the blood. The consistent bloody fluid found in the stomach is also probably partly due to this anti-coagulant factor.

The mechanism of fluorid toxicity appears to be most logically on the basis of a combination of a fluorid ion on calcium metabolism, as suggested by Kobert and others, as well as from its inhibitory action on lipase and other enzymes as reported by Amberg and Loevenhart.[16] According to Embden and Lange,[17] and Embden and Hentschel,[18] the presence of increased amounts of fluorid ion interferes with equilibrium between lactocidogen, lactic acid and phosphoric acid in the blood stream. This, as De Eds[15] suggests, may contribute, in interfering with the physiology of normal muscle contraction, to the extreme weakness experienced by these patients. From pathologic observations it is apparent that the salt acts as an acute protoplasmic poison, and the cloudy swelling and early cytoplasmic damage which is seen in all of these cases is the result of its influence.

While none of these cases of either accidental or voluntary intoxication were apprehended early enough to attempt the administration of a remedy, it has been suggested by Vallée, and Stanton and Kahn that administration of a soluble calcium salt would, to a great degree, bind the mobile fluorid ion and result in detoxification. Large amounts of milk have been suggested and used with some benefit, due probably to the calcium effect, while Stanton and Kahn[19] report a case that recovered after a lethal dose of sodium fluorid, which was treated by massive gastric lavage, lime water and calcium chlorid.

CONCLUSIONS*

1. Five cases of acute fluorid poisoning are reported which corroborate the clinical and pathologic findings of previous reports.
2. Terminal cutaneous petechial hemorrhages are observed, and their presence attributed to the anti-coagulant action of fluorin.
3. The mechanism of fluorid toxicity is probably due to a combination of formation of an insoluble calcium salt, and by the interference of the action of enzymes and lactic acid metabolism.
4. Three grams is a sufficient quantity to cause death in man.
5. Gastric lavage and subsequent stomach washing with lime water, milk, or other calcium salts, are at present the most proper treatment.

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DISCUSSION OF PAPERS OF DRS. GEIGER AND CARR

P. J. Hanzlik, M. D. (Stanford University School of Medicine, San Francisco).—Doctor Geiger's paper covers the problems of acute and chronic fluorid poisoning so well that I can add but little more than approval. Doctor Geiger suggests the proper remedy for avoidance of such a shocking occurrence as happened in San Francisco, and the public is clearly entitled to that protection. No one today, who fully understands the phenomena of chronic intoxication, would disagree with the contention that insecticides and spray residues constitute a public hazard of large proportions. Minute quantities of these poisons act so insidiously and slowly that they may actually be the etiologic factors in some common disorders, the symptoms being much alike. Fluorid, in any form, is one of the most dangerous insecticides and contaminants of natural foods and waters. So-called "mottled enamel" or bleaching of growing teeth in animals occurs after taking in food something like only fourteen parts per million of fluorid, and in children one part per million. There are probably other systemic abnormalities caused by prolonged ingestion of fluorid. The action is apparently not a simple matter of decalcification, because calcium fluorid produces the same effects. What is fundamentally involved in fluorosis is as yet undetermined, although some intrinsic impairment of protoplasm and enzymes appears plausible, which merely emphasizes the insidiousness of this intoxication. The complete elimination of fluorin as an insecticide, and use of soils and waters where it is a contaminant is the only remedy at present. Constructive work on insecticides should concern itself with the development of volatile organic substances which leave no residues, in order to eliminate all hazards to health. This paper again indicates Doctor Geiger's alertness and constructive attitude on all matters pertaining to the health of the people.

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P. J. Hanzlik, M. D. (Stanford University School of Medicine, San Francisco).—Doctor Carr's summary brings up to date practically all that is known about acute fluorid poisoning. The disionization of calcium in the blood and tissues is undoubtedly responsible for the symptoms and tissue changes of the acute poisoning, and the more soluble the fluorid the more rapid the onset and more violent

the symptoms, as occurred in these cases. Chronic poisoning is, of course, different fundamentally, since calcium fluorid and insoluble fluosilicates produce the intoxication quite readily. Calcium is the choice antidote for acute poisoning and should be used locally and systemically, the gluconate being better tolerated than the chlorid, both intramuscularly and intravenously. Charcoal can be profitably given in liberal quantities and left in the stomach after the lavage is completed. Tremors or convulsions, if present, can be controlled with barbital. According to Doctor Carr, the total fatal dose for a man is much smaller than has been frequently supposed. In the presence of food, recovery can probably result from larger quantities.

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C. D. Leake, Ph.D. (University of California Medical School, San Francisco).—As Professor P. J. Hanzlik of Stanford University has remarked in other discussions of reports by Doctor Geiger and the members of the staff of the Department of Public Health of San Francisco, the citizens and medical profession of the city may be extremely grateful for their splendid work. Doctor Geiger has developed a technique of frankness and honesty in his relation with the public and the profession which is almost unique, but which has been responsible for great and significant improvement in public health matters in San Francisco. The promptness with which Doctor Geiger and Doctor Carr are reporting to their scientific colleagues the essential facts in the recent fluorin poisonings in San Francisco is eloquent testimony of their desire to coöperate fully with their colleagues in every affair concerning public health. The difficulty of arriving at an accurate picture of the unfortunate situation is graphically described by Doctor Geiger. There is no doubt but that this incident will serve to bring about much more satisfactory public health control of hitherto unregulated food and drug dealers. It will also serve to bring to the city chemist improved apparatus and facilities which he has for so long needed.

Doctor Carr's report is an excellent review of the essential features in acute fluorin poisoning. The widespread use of various fluorids in pest control makes it necessary that all physicians be aware of the possibility of acute poisoning from these substances. The protection of water supplies to prevent chronic fluorin intoxication is a public health matter, and physicians must also be familiar with the symptoms of such poisoning. The review made by De Eds (*Medicine*, 12:1, 1933) is the best available on this matter.

It is interesting that the amounts of sodium fluorid taken by the individuals mentioned in Doctor Geiger's and Doctor Carr's reports is in the range of the minimal fatal dose that we found in animals. We found that 87 milligrams per kilogram would kill about half of the animals into which it was intravenously injected, and later we found that approximately this same dosage given by mouth was also in the minimal toxic range. This latter work was not reported. It was our opinion that the chief factor in acute fluorid poisoning is calcium precipitation. However, we brought forward definite evidence to indicate inhibition of enzyme action throughout the body (*American Journal of Physiology*, 90:426, 1929). We had previously found (*American Journal of Physiology*, 76: 234, 1926) that sodium fluorid by mouth is extremely irritating to the stomach mucosa, rapidly producing marked congestion and erosion in high concentrations. Although the weights of the patient referred to are not given, they took amounts of sodium fluorid apparently around three grams or more. Since there were two elderly women who died and one old man, it may be assumed that their weights were not very great and that they ingested and absorbed amounts of sodium fluorid in the range of 60 to 90 milligrams per kilogram.

The fluorids constitute a definite public health hazard, both from the standpoint of the accidental or suicidal ingestion of insect powders or chronic poisoning from contaminated water supplies. These reports by Doctor Geiger and Doctor Carr comprise an excellent survey of these dangers, and of the necessity of attempting to control them.

PSYCHIATRY AND THE LAW*

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Discussion *by Walter Rapaport, M.D., Imola; J. M. Scanland, M.D., Agnew; Margaret H. Smyth, M.D., Stockton.*

MUCH confusion has existed in the minds of laymen as well as physicians, and also in the minds of attorneys regarding the use of the term "insanity." Many maintain that the term is purely medical, while others as seriously contend that it is a legal contribution, both as to name and as to conception. Glueck states that the specific term "insanity" seems first to have been introduced into the law by medical experts, finally superseding such terms as madness, lunacy and mental unsoundness, which were borrowed from the very imperfect psychiatric knowledge of the day. The word "insanity" seems to have been quite generally used by commentators on the law in early times, and it is probable that all such terms were popularly used until they were taken over by the first systematic writers both in law and in psychiatry, and applied to this specialized field.

RULES OF LAW GOVERNING INSANITY AS A DEFENSE TO CRIME

The rules of law governing insanity as a defense to crime are vague and confused; clearly unsound in that they are based upon notions of the mental disorder discredited by medical science. Owing to the careless use of language by judges and others in the law, insanity has become synonymous with criminal irresponsibility, by reason of a certain type and degree of mental disorder which was noted far in advance by means of artificial tests of criminal responsibility. Because the law has preëmpted the term "insanity" and specialized it, judges frequently employ the term in the sense of irresponsibility, while psychiatrists seek other terms to distinguish the mentally-ill without reference to criminal responsibility. This practice has resulted in judges on the bench frequently attempting to distinguish between "legal insanity" and "medical insanity." This subject has been under discussion by English and American courts, legislators, and legal writers for more than a century. As long ago as 1800 the brilliant Lord Erskine, in his argument as counsel in the trial of Hadfield, attempted to lay down a universal test of responsibility in cases where the defendant suffered from a mental disease. His effort and the efforts of others have yet failed to attain clarity and uniformity; and even to this date, no universal test of responsibility has been generally adopted. There are many reasons for this; but for a branch of learning which has as a specialized objective largely the definition of words and their making, the law is strangely lax in its use of the term. Unfortunately, the word has no technical meaning either in law or in medicine, and is used by the courts and by legislators ordinarily to convey either one or two meanings:

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-fourth annual session, Yosemite National Park, May 13-16, 1935.

(1) A type or degree of mental defect or disease, or (2) Such a degree of mental defect or disease as to entail legal consequences, as for example commitment to a state institution, appointment of a guardian, or to avoid a contract or relieve responsibility for crime.

Many states have a provision in law that no act can be punished which was done "in a state of insanity," or while the person "is insane." In one decision, this was held to mean that no act done by a person suffering from a mental disorder of any sort could be punished. On the other hand, it is generally held that persons are exempt from punishment only when so mentally disordered as to come within the test of responsibility which has been established or accepted in the particular jurisdiction served by the court. Great clarification would immediately result if the term "insanity" could be eliminated, and in its place the use of some other term as, for example, "mental disorder" or "psychosis," or by the use of a more specific term when referring to the medical concept of mental ill health, and other terms clearly legal to describe the concept having to do with the lack of responsibility by reason of insanity at the time the crime was charged, or present insanity at the time of the criminal proceedings.

PRESENT ATTITUDE OF CALIFORNIA COURTS TO INSANITY

For the purpose of this discussion, the present attitude of the courts relative to insanity in California is attempted, so that our conception concerning the term "insanity" and its implications when used as a defense for crime may be better understood and at the same time pertinent facts may be submitted which permit a more intelligent service by physicians who may be called to serve the courts. From a recent charge to a jury in the Superior Court in this State, one may find clearly the attitude of the Bar toward the plea "not guilty by reason of insanity" as usually permitted as a defense for crime. This particular Superior Judge stated that the general test which is recognized by the law in California as being the test by which to determine whether or not a person charged with a crime should be held responsible for his acts or should be excused because of some diseased mental condition, is called the Right and Wrong Test:

"The law presumes every man to be sane and to possess a sufficient degree of reason to be responsible for his crimes until the contrary is proven. To establish a defense on the ground of insanity, it must be clearly proven that at the time of the committing of the act the party accused was laboring under such a defect of reason from a disease of the mind as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong.

"It is at once apparent from a mere statement of this test that there are many persons suffering from various degrees and kinds of mental diseases, and who for most purposes would ordinarily be regarded as insane, but who nevertheless have sufficient mentality to know the nature and quality of their acts and to know that what they are doing, or may do, is wrong, and who, therefore, are to be called sane under the legal test just given. The law is thoroughly aware that under the right and wrong test, persons who are mentally diseased may nevertheless be found to be sane, but the reason for the character of the test is to be found in the purpose for which the test is used. The right and wrong test was never intended as a method of determining the existence or nonexistence of mental disease. It was intended as a method of determining whether persons charged with crime should or should not be relieved of the ordinary consequences of their acts by reason of a diseased mental condition. The law does not recognize a diseased mental condition as being of itself a defense to crime any more than it so recognizes a diseased physical condition; and a diseased mental condition relieves a person charged with crime of the consequences of his acts only when his defect of reason is such that he is not aware of the wrongful nature of his act."

FINDINGS OF THE EXAMINING PHYSICIAN

With this clearly in mind, a physician called to examine a person who has entered such a plea must find that the patient at the time of the commission of the crime must have been so deranged mentally as to be unable to determine the difference between right and wrong. He must have been so seriously deranged mentally as to be unaware of his surroundings: unable to tell where he was, who he was: or properly identify persons with whom he was associated or with whom he came in contact. He must have been, because of his mental disorder, so greatly deranged as to be unable to appreciate the action of the court or confer with counsel relative to his own defense. He must be unaware that the commission of a crime results in punishment, and must be unable to understand that if guilty of the crime charged, he will be punished by commitment to the penitentiary or punished in some other manner.

CALIFORNIA LAW REGARDING COMMISSIONS OF THREE PHYSICIANS

In this State the law permits the court to appoint a commission consisting of not more than three physicians, one of whom shall be an active member of the staff of the state hospitals, and either of the other two may or may not be a trained psychiatrist, but each must have had experience concerning insanity in order that they shall advise the court relative to the findings after examining the defendant in court and hearing the testimony given. In criminal proceedings the defense, as well as the prosecution, is permitted to employ alienists who are presumed to have special knowledge governing mental disorders, and who are expected to testify from examinations made, from information received, and from observation in the court, their conclusions relative to the mental capacity of the defendant. The commission appointed by the court is expected to reserve its opinion until all the testimony is in, and then arrive at an opinion when all the facts are in its possession. The commission is presumed to be entirely impartial; the presence of members of the commission in the court is in the capacity of expert advisors to the court itself. The jury makes the final decision, and in spite of the testimony of experts and alienists who may appear, the decision of the jury is final, and when the jury determines the mental capacity of the defendant, such a decision must stand as a part of

the record of the court. Alienists and other physicians are often times expected to testify from a series of hypothetical questions presumed to cover the testimony introduced, and from such questions draw the conclusion as to the insanity of the hypothetical person, well known to all to be the defendant in the case.

RESPONSIBILITY OF THE INDIVIDUAL PHYSICIAN AS A PSYCHIATRIC EXPERT

A psychiatrist or other physician appointed by the court or employed by either the prosecution or defense to examine a person charged with a crime whose defense is a plea of "not guilty by reason of insanity," must appreciate that his determination in the case under present court procedure is one of responsibility or lack of responsibility governing the action of the patient at the time of the commission of the crime charged. The physician must secure a very complete history, even going back to the ancestry of the defendant to determine any mental trends, diseases, or disorders in the family tree. He must secure information concerning the birth of the person; his infancy, any facts having to do with abnormalities of birth; delayed development as demonstrated in delayed walking or talking; any serious diseases from which the patient suffered in infancy. He must rather clearly distinguish the amount of schooling the patient received, his adjustment to school life, subjects in which he excelled, his general information acquired since leaving school, his general reaction to his environment up to the time of the commission of the crime, as well as his adjustmejnt to society and to business or to his profession. He should determine the reaction of the patient to the facts relative to the commission of the crime and to the events immediately subsequent to the commission of the crime. Did the prisoner or patient plan the crime with any degree of intelligence; was the plan reasonably successfully carried out; after the crime was committed, was a reasonable attempt made to conceal the crime; did the patient attempt to evade arrest and conceal himself from the police, and did he attempt to escape? What was his attitude at the time of arrest and since his confinement; his philosophy of life relative to the commission of the crime, the value of property, sacredness of person? The presence of delusions or hallucinations, if found, should be carefully analyzed to determine if there is any relationship between such delusions and hallucinations and the crime committed. Does the prisoner have sufficient memory, recent and remote, to remember reasonable events, both before and after the time the crime was committed; is he sly in his attitude toward the physician, and does he attempt to conceal pertinent facts relative to the crime for the purpose of exonerating himself from blame?

PROCEDURE WHEN IT IS CLAIMED A PERSON IS INSANE

In the State of California physicians are concerned with another phase of the term "insanity" and its implications as applied to persons suffering with mental disorders. A person may be found in his home to be suffering with a disorder of mind that in the opinion of his relatives or neighbors makes him dangerous to be at large. When such is true, the interested person proceeds to the office of the district attorney where an affidavit is filed in which the offending party is alleged to be insane. The affidavit must definitely state that there is a degree of mental unsoundness to an extent as to endanger the life of the person concerned; the lives of his immediate associates or members of his family, and that the person so concerned is also a menace to property. Under such conditions, the court of proper jurisdiction issues a "warrant of apprehension," and when such warrant is issued, it is placed in the hands of a police officer or a deputy sheriff, who calls at the home of the patient and takes him into custody, and delivers such a patient to a place of detention—the county jail, a room in a county hospital or, in the larger counties, the psychopathic ward, where he is held for a period of observation.

Shortly after his delivery to the psychopathic ward or some other place of detention, it is necessary under the present court procedure in this state, to "arraign" the prisoner. The judge appears before the patient or the "prisoner" so confined, and reads to him the affidavit, or makes a statement containing the pertinent facts contained in the affidavit, and indicates to him that the time for hearing is set for a given future date; that he may have the benefit of counsel; that he may have witnesses subpoenaed who will be required to testify in his behalf. He is also informed that if he is found to be insane and committed to a state hospital, he may have the right to appeal, provided the appeal is made within five days after such commitment, at which time his case will be tried in the Superior Court in the presence of a jury who will determine, on the basis of his appeal, whether or not he is insane. It is the experience of all persons who have to do with the detention of patients charged under such warrants, that not infrequently the judge makes this formal statement to patients who are in the midst of manic excitement from many of the various psychoses from which they suffer, or who are so confused in mind as to be unable to distinguish their location or the persons surrounding them, and in some cases they are even unable to determine their own identity. On the date set for hearing, such persons are personally brought into court and in the presence of witnesses, who may be loved ones and neighbors, the court hears the testimony relative to the mental disorder from which the patient suffers, particularly the erratic behavior, if such be present, or peculiarities manifested to these interested friends and neighbors who have led to the issuance of the warrant. The court appoints two physicians who may or may not be psychiatrists to hear such testimony, and in the presence of the court these physicians prepare a blank which is required by the state hospital service

covering pertinent facts pertaining to the history and mental examinations. After a very short period of observation and with the testimony in their minds, these two physicians are expected to recommend to the judge concerning the sanity of the person concerned, and as to whether or not he should be committed to a state hospital. The judge is not bound to follow these recommendations, but may determine individually as to the disposition of the case. However, under ordinary conditions, he accepts the recommendations of the two physicians appointed, and if the recommendation is commitment, the patient is committed. The judge may also, in his discretion, discharge the patient from further custody of the court, even though the person has a well marked psychosis, but is not shown to be a menace to other persons or property.

CRITICISM OF THE PRESENT LAW OF COMMITMENTS

This procedure has come to be known in loose language as "a finding in medical insanity." The law under which such commitments are made, with certain modifications and amendments, dates back to more than half a century. Modern thought is in favor of doing away with this apparent criminal approach to persons long recognized as suffering from a mental illness. The present law does not presume to take into consideration the simple fact that the person under consideration is suffering with a mental disorder and requires institutional care, unless it is found that such a person, by virtue of behavior already shown, becomes a community menace. Attempts have been made to modify the law to permit a more scientific approach with the simplification of court machinery to permit the admission of mentally sick individuals to state hospitals without the stigma that is always incidental to such court action.

DEVELOPMENT OF PSYCHOSIS SUBSEQUENT TO COMMISSION OF A CRIME

Between the time of the commission of a crime and the date of trial, a patient confined in a prison awaiting trial may develop a psychosis. If such is found to be true, the court orders a hearing to be conducted under conditions similar to those of a civil commitment just described. If the prisoner is found to be insane, but it is determined that his insanity has no relationship to the time of the commission of the crime charged, he is sent to a state hospital where he remains until his mental condition is sufficiently recovered so that he may be discharged. It is a requirement of law that when such a person is discharged from the state hospital, he must be returned to the sheriff of the county of original jurisdiction, and the district attorney is required to proceed to prosecute the case under the original indictment which refers to the crime committed. The fact that he has been a patient in a state hospital does not have any bearing upon the case if it is at this time shown that the patient was responsible at the time of the commission of the crime.

THE TERM "PSYCHOSIS," FROM THE MEDICAL AND LEGAL POINTS OF VIEW

The term "psychosis" now has a modern usage to indicate the presence of a mental disease, and is used to define a mental disorder of a functional type or one organic in origin. It is used in the practice of medicine by physicians who are careful of their language and properly by psychiatrists in discussing mental diseases, and has no relationship whatever to the legal aspects in any given case. The term itself does not take into account menace to property or person, nor does it have any relationship to responsibility to the law or the ability on the part of the patient to distinguish between right and wrong. The classification of the American Psychiatric Association should be the basis of all findings in the practice of medicine by psychiatrists in dealing with mental patients. If this terminology is used, it will tend to eliminate from our ordinary work the use of the term "insanity," which has no connection or relationship whatever to the term "psychosis," and it will enable the intelligent physician to properly distinguish and label the presence of mental diseases without the use of this term.

ETHICS RELATING TO EXPERT TESTIMONY OF ALIENISTS

Psychometric tests as such are not required to be covered in the testimony of alienists, but are important in their hands to assist in decisions relative to responsibility. Even in the presence of a mental disorder under our present court procedure, insanity as a defense for crime may not be shown. An alienist who is retained by either side in a case involving the commission of a crime should accept a retainer only for the purpose of making an examination of the prisoner, after which he should render a report to the attorney who arranged for such examination. He should draw his conclusion quite independently of any interests the counsel for the defendant may have in his examination. If he is retained by the prosecution and after a complete investigation has been made, concludes that the patient is not insane, he may then properly agree to testify for the prosecution. If, on the other hand, he finds that the patient is insane, he is similarly bound to make such a report to the prosecution and to state his position clearly when, under ordinary conditions, he will not be permitted to testify for that side. He should not, according to professional ethics, testify in opposition to the side for which he made his original examination. The literature contains many opposing decisions relative to this particular matter, but it is generally agreed that "to require a physician to render expert testimony without proper compensation would, in the last analysis, be antisocial." It is also considered that a reputable attorney dealing with a reputable physician would not arrange for testimony to be given by such a physician if he had been retained by the counsel for the opposing side and for whom the original examination was made, even though his testimony were not used by the side that originally retained him.

ATTITUDE IN COURT OF PHYSICIAN WHO TESTIFIES

A physician should not be concerned with the ultimate guilt or innocence of the prisoner examined. He should assume the attitude that his information has been acquired in a legitimate manner, and he is coming into court having been properly retained to give expert opinion for the benefit of the court and jury in order that findings of justice to the prisoner may be made. An alienist should never appear in court without having carefully prepared his case. He should not only know the case at hand, but he should be familiar with the literature, both medical and legal, governing such cases, and as it applies to conditions under which he is working. He should assume a neutral attitude, being truthful in his answers, and sincere and impartial in his testimony and the deductions made from the testimony. Only under such conditions may alienists expect to demand and retain the respect which is due them as expert witnesses in criminal cases where insanity is an issue.

Highland Hospital.

DISCUSSION

WALTER RAPAPORT, M.D. (Napa State Hospital, Imola). I wish to add my word of approval for the elimination of the word "insanity" from medical diction and the relegation of that term entirely to legal terminology. I never use it in a medical sense, in or out of court, and that fact alone has saved me the embarrassment of quibbling over so-called medical and legal insanity.

One phase of the question of insanity has not been touched upon by Doctor Black, and that is when the question arises after arraignment and before the termination of the trial. If it appears to the court, either by suggestion of counsel or by any other means, that a defendant has not sufficient mental capacity to proceed with his defense, the court interrupts the trial and directs an inquiry into the mental capacity of the accused. In that case the requirements are a little different from that in the issue of insanity regarding the defense.

The question of the last aforementioned instance is not whether the accused is suffering from a mental disease, but whether or not the accused has sufficient mental capacity to understand what is going on, and to assist his counsel in the conduct of his defense.

While it is true that the mere showing of the presence of mental deficiency is not a defense to crime, yet here, as in all other questions of criminal procedure, the question of intent is relevant. Therefore, if the mental age of the individual is so low that he would not be able, by reason thereof, to form an intent, then it would be material as a defense. In many states it has been decided that the mental age of seven years is the dividing line below which the assumption is that the accused would not have sufficient intelligence to form an intent.

When a showing is made that a psychosis has been developed subsequent to conviction, the individual may be treated in the prison or sent to a state hospital for the insane for treatment. If he should recover before the expiration of his sentence, he is returned to the prison for completion of his sentence. If he does not recover prior to the completion of his sentence, his status changes at the termination of his sentence to that of an ordinarily committed insane person. If the sentence is capital punishment, and the individual develops a psychosis before the sentence is carried out, the sentence is stayed until he recovers. He may, during this time, be kept at the prison or be sent to a state hospital for the insane, to be returned as before mentioned.

The question of the relationship between a person suffering from mental disease and the making of contracts is also a pertinent one, but does not concern us in the present discussion.

The expert frequently invites undeserved condemnation because of his lack of understanding of what is required of him. I have heard it said that a medical expert should confine himself to medicine and disregard all else.

To follow this advice implicitly leads to trouble, because it permits of much speculation and theorization; all permissible and commendable in medicine, but in the court it frequently only adds confusion. The court is interested only in the case at bar. It is not interested in what might happen in many and divers situations, but what it can reasonably be supposed did happen in the present situation. The court sets out what the law is, and what the law requires and expects. The expert should confine himself to these restrictions and attempt, if possible, to give his best judgment in the matter. The fact that the expert does not feel that the law is correct is not his problem in court. If he is interested in espousing his theories and speculations of what the law should be, he should do so before the legislature and not during his appearance in court.

It is conceded that certain peculiarities and even frank psychoses might be present in the accused. But in a plea of not guilty by reason of insanity, that is not the point at issue. Doctor Black has told you what the points at issue are; and, unless these peculiarities or psychotic manifestations are such as to meet the legal requirements of insanity, opinions on that score are immaterial and inconsequential, and if indulged in by the witness only befuddle and confuse the issue and bring contempt on the expert.

The issue of peculiarities or psychotic manifestations are material during the trial if, by reason of them, the accused cannot conduct his defense; or if, after conviction, the accused is found to be suffering from a psychosis, he may be directed to an institution for the treatment of his mental condition without disturbing the issue of guilt or innocence.

There is an element of law enforcement to which all should contribute their efforts, and it is not the duty nor the right of an expert to interject immaterial, speculative, or highly improbable opinions with the view that, by giving such opinions, he might help his client or give voice to his disapproval of existing jurisprudence.

Undoubtedly, there is much in medical jurisprudence that could be improved upon to the benefit of all concerned, and it would be, perhaps, an excellent move if this section were to have a standing and permanent committee whose duty it should be to study the problem to the end that better legislative action could be had. But the courtroom, at the time of a trial, is not the place nor the time for such activity.

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J. M. SCANLAND, M. D. (Agnew State Hospital, Agnew).—The subject of psychiatry and the law is one in which we are especially interested. We of our specialty are frequently "ordered" to give expert testimony in superior courts as psychiatrists, when the plea of "Not guilty by reason of insanity" has been entered as defense for crime, and in other cases in which the subject of insanity is an issue.

I agree with Doctor Black that the term "psychosis" is far preferable to that of insanity, and think we should school ourselves in the use of the more dignified and professional expression. To an extent, too, as Doctor Black has so well said, the use of the word "psychosis" rather than "insanity" might bring to juries and courts a better understanding of our conception of medico-legal responsibilities. However, it is likely that clever lawyers would soon come to define the term "psychosis" as it may apply to the subject of expert medical testimony to be much, if not quite the same, as is the present interpretation by the courts of the legal meaning of insanity.

Doctor Black, in his article, has referred to an interpretation and explanation of the laws of California by a Superior Court judge in a written summarization prepared for the guidance of medical witnesses in procedures in which insanity is a question, and in which it is clearly set forth that "the only test of insanity which is recognized in criminal cases is the right and wrong test."

The State Supreme Court has more than once ruled on the subject of such evidence, and states in an opinion of a certain case:

"Responsibility depends on whether the defendant knew the nature and quality of the act at the time of its com-

mission, and the wrongfulness of the act. If he had sufficient mental capacity to know what he was doing, and to know that it was wrong, he is legally accountable for his act. Even though he may be mentally abnormal or defective, or may suffer from some nervous disorder, he is, under our law, held to full responsibility for his act unless the evidence brings him within the strict legal meaning of insanity."

This then is the law, and certainly it is not within our province, nor is it our intention or desire to question an opinion from such a source.

Another law, however, if added to the statutes of the State would, in my opinion, simplify and probably clarify this problem of psychiatric expert testimony. I have in mind and suggest an amendment of an existing law providing that Superior Court judges in cases in which defendants have pleaded "Not guilty by reason of insanity," appoint medical commissions as is now provided, adding a mandate to the effect that no other medical testimony be admissible.

An objection might be raised to this that such an act would be discriminatory, and therefore unconstitutional; but it would seem to me that Superior Court judges should have this latitude and authority in such cases, and that legislation to this effect could be created in a manner that would be constitutional.

Or, a law might be passed in this State similar to those in effect in other states, making provision that the Superior Court judges in cases wherein insanity is entered as defense be empowered to order the defendant confined in a state hospital for a period of not less than thirty nor more than sixty days for an examination by the superintendents and medical staffs of state hospitals, who will be required to give an opinion to the court as to the sanity or insanity of defendant at the time of the commission of the crime.

The statute now in effect provides that in such cases the Superior Court judge presiding must appoint two or more physicians to "examine defendant and otherwise inform themselves concerning his mental condition." In accordance with the provisions of this statute, Section 1027 of the Penal Code of California, the judge orders these alienists by him appointed to "examine the said defendant and investigate his sanity and to testify in court in reference thereto." Under this law both attorneys for the defendant and attorneys for the State may question, and cross-question, and examine the medical experts as freely as may the judge.

It would surely seem that this procedure should bring out all the worthwhile expert testimony necessary to the case on trial, and is a fair and just and comprehensive presentation of expert medical evidence.

If then, as above suggested, no other medical testimony be permitted in such cases, and if no other alienists be called by attorneys for the people, the ends of justice would be better served. How often have we seen a doctor or group of doctors offering expert testimony on one side of a case in court, and another or more doctors on the other, each side earnestly testifying to opinions, and even that which they profess to believe to be facts, that are entirely different one from the other; and it seems equally ridiculous that a jury of laymen may be expected to pick and choose between experts who testify to conflicting opinions. And if experts cannot agree, certainly juries cannot be expected to agree.

This imposition on the public and on our profession could, I believe, be remedied by the enactment of a short statutory provision as above suggested.

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MARGARET H. SMYTH, M.D. (Medical Director and Superintendent of Stockton State Hospital, Stockton).—Psychiatry and the law have been running on parallel lines for a long time, but the indications seem to be that the lines are changing their direction and fusing into better comprehension of the two viewpoints in so far that both lawyers and medical men show a dissatisfaction with present meaning and procedure.

The term "insanity," to which blind custom and habit seem to have given a fixed place in legal and medical diction, possibly has had a legitimate excuse for being when first formulated, which the title of Doctor Black's paper points out. The legal side of psychiatry is certainly an important one, and especially so from the standpoint of responsibility.

A person suffering from a serious mental disorder is sent to a state hospital unless he has private means to be cared for elsewhere. In case a commitment is considered, legal procedure becomes necessary. The procedure in this and in many of our states could be changed in some respects with considerable benefit to the patient. It is encouraging to see better and more widespread understanding of modern psychiatry in the past several years, with psychiatric wards provided in many of our county hospitals and with deputies endeavoring to improve their methods in conveying their charges to the hospitals. A mental patient arrives at the hospital in a far more comfortable state than was true some ten or fifteen years ago, at which time a large number arrived in full restraint, fearful and uncomfortable.

The law now offers voluntary admission of patients on written request to the superintendent of the hospital. This law is being taken advantage of to such an extent that at the present time the six state hospitals in California have under care for treatment ond observation 504 voluntary patients. This plainly shows the course a mental patient with some insight will follow if medical aid is offered, and without the necessity of resorting to legal measures for admission to a hospital giving the patient the benefit of early treatment for his particular illness.

As for a trial by jury when required to determine sanity or insanity of a defendant, when the time comes for a medical man to ask the opinion of a jury as to whether a patient is suffering from chicken pox or smallpox, the psychiatrist may then hope to request a jury to sit on a case of dementia praecox or paresis. However, it is for the determination of sanity or insanity that the jury is called. The jury gleans its information from witnesses and the testimony given by physicians appointed by the judge of the court or called on the case. One cannot be too critical of the findings of the jury of inexperienced men when, in certain instances, the medical experts themselves disagree as to the diagnosis in the individual's case.

Psychiatry, I believe, is one of the most important branches of medicine, and I am in agreement with Doctor Black's statement that the classification of the American Psychiatric Association should be the basis of all findings in the practice of medicine by psychiatrists in dealing with mental patients.

FRESNO COUNTY PART-PAY PLAN*

By H. M. GINSBURG, M.D.
Fresno

DISCUSSION *by A. E. Anderson, M.D., Fresno; John Hunt Shephard, M.D., San Jose; Charles A. Dukes, M.D., Oakland.*

A BRIEF summary of the Fresno County part-pay plan is submitted to show number of cases and results between July 7, 1933 (the date of its inauguration), and December 1, 1935. The plan was slow in its showing, due, first to a lack of medical social service workers, and, second, the fact that the plan was new and workers were reluctant to refer cases with small fees. The medical social service department, under the supervision of trained medical social workers, was not established in the General Hospital until October 1, 1934, and yet, as will be seen in the statistical report, it is a vital factor in the working of the plan.

HOW THE FRESNO PLAN FUNCTIONS

The plan has been outlined previously and, briefly, functions as follows: The medical social

* From the Directors' Department of the General Hospital of Fresno County.

service department, located at the General Hospital, after interviewing patients, rates them into one of three classes. The first class (well-to-do) and third class (indigents) are cared for by their private physicians and General Hospital, respectively. The second class is rated according to its illness and ability to pay, and is referred to its physician of choice, or physician selected by rotation, with case history (financial and social) which specifies the amount patient is able to pay for the treatment. The physicians selected by rotation are taken from a panel supplied by the Fresno County Medical Society. The physicians on this panel have agreed to accept the recommendations of the medical social service department and, in case of doubt, the patient can be referred back for a second social report. It was felt that in a community the size of Fresno County, where three-fourths of the physicians are located in the city of Fresno, it would be better to have the patient report to the medical social service department and then be referred to the physicians, rather than have physicians interview the patients first and then send them to the service department to determine financial status. In this manner the physicians are not called upon to treat indigents in the home when they should be cared for at the county institution. The coöperation of the medical profession is essential to the proper working of the plan.

REPORT ON 588 CASES

From August 7, 1933, to October 1, 1935 (previous to establishment of the medical social service department) 149 cases were referred to private physicians. With the establishment of the department there have been referred, from October 1, 1934, to December 1, 1935, a total of 439 cases. This points out the value of trained workers. The total for the plan is 588 cases, divided as illustrated in Chart 1.

CHART 1.—*Fresno County Part-Pay Plan: Distribution Chart*

August 7, 1933, to December 1, 1935

Type of Case	Amount Payable	Number of Cases
Obstetrical	$35.00	2
	25.00	31
	20.00	4
Circumcision	15.00	3
	5.00	1
Tonsils, Adenoids and Circumcision	30.00	1
	25.00	1
	20.00	1
Tonsils-Adenoids	25.00	7
	20.00	8
	15.00	42
	10.00	38
	7.50	1
Office visits (Includes major and minor surgical cases listed in regular fee)	Regular or full fee	164
	50c per call	2
	75c per call	6
	1.00 per call	88
	1.50 per call	124
	2.00 per call	27
	2.50 per call	9
	3.00 per call	1
	4.00 per call	1
Dentist	Full fee	5
Shelter camp		2
Other counties		19
Total		588

COMMENT

These cases do not figure the return visits made. If we assume that each patient returned on an average of three to four times, it would swell the visits made to about two thousand.

In all cases the medical social service department impresses the patients that their services must be for a cash consideration, and in the majority of cases it has so worked. Classified among the regular or full-fee office cases are major and minor surgical cases which have not been enumerated. The hospitals in this county, whenever necessary, have modified their rates according to request of medical social workers.

The patients have been satisfied, and repeatedly have expressed themselves as happy over the fact that they are able to secure private care at moderate rates. It is felt that the plan will show better results in the future.

The panel of physicians, when first compiled, was segregated as to surgeons, gynecologists, urologists, etc. It was found, after one year's experience, that it was better to have one straight panel, without divided specialties, and if a physician did not care for a particular type of case he could refer it to another physician of his group, or the medical social department would contact another physician.

General Hospital of Fresno County.

DISCUSSION

A. E. ANDERSON, M. D. (1759 Fulton Street, Fresno).—The Fresno County Part-Pay Plan is an adaptation of the Alameda plan. It differs from the Alameda plan in that the patient first sees the social service worker instead of being referred by the physician to the social service.

The Fresno County Medical Society, conferring with the County Board of Supervisors, secured the adoption of this method of providing medical service for patients unable to pay the usual fees, but not in the indigent class, early in 1933. Until a trained social service worker was provided October 1, 1934, only a negligible number of patients were referred to physicians under this plan. During the period from October 1, 1934, to December 1, 1935, a total of 439 cases were referred, showing a very gratifying increase in the use of this service.

The social service work is done by one trained and two untrained members of this department at the County Hospital. The admissions to the hospital for the year 1935 were 7,100, and to the out-clinic 6,200. The investigation of this great number of patients is necessarily inadequate, and could be improved by additional workers.

Only occasionally can hospital facilities at private hospitals be arranged for under this plan. The Social Service Department emphasizes the need of prepaid hospital service in order to make this plan really effective. The lack of cash to pay the private hospital is a very frequent reason for admission as a charity case, when the patient states he can arrange for the medical services needed. The doctor is willing to take a chance on future payment for his services, but the patient, unable to pay the private hospital, is classed with the indigents, and so admitted.

Some seventy members of the Fresno County Medical Society have agreed to take care of these patients at whatever fee they can pay.

There are no definite or fixed rules for determining eligibility for this service. The social service tries to ascertain the personal need and inability to provide needed care by a private physician or at a private hospital.

My impressions lead me to the conclusion that in order to make this plan most useful, especially in cases of serious illness, we must have other hospital facility arrangements such as could be provided by hospital insurance.

JOHN HUNT SHEPHARD, M. D. (609 Medico-Dental Building, San Jose).—The report of Dr. H. M. Ginsburg on the operation of the Fresno County Part-Pay Plan furnishes some valuable food for thought.

One of the chief things that impressed me when I read the report is the fact that 164 of the 588 patients (27.88 per cent) investigated by the Social Service Department, were not entitled to receive services at reduced fees. While 588 cases is too small a number upon which to base definite conclusions, it becomes a very significant factor when considered from the viewpoint of health insurance. This 27.88 per cent may justly be considered chiselers, attempting to get something to which they are not entitled. It is interesting that this percentage of chiselers very closely corresponds to the abuse found in some of the European health services, and consequently, if and when any form of health insurance is adopted in this country, there must be added to the estimated cost 25 or 30 per cent to cover the abuse of privileges in one form or another.

While it appears that the fees received for much of the work is near or below the cost level to the doctor, the fact that these patients have been saved their self-respect and prevented from becoming patrons of public charity is of great value, for when a person once receives public charity in any form he is very apt to become a permanent dependent member of society and a supporter of the various types of "give me" legislation.

I believe that the doctors in Fresno County, in caring for this economically embarrassed group, are acting in accordance with the ideals of medicine, and will help many persons maintain their independent existence and pride of citizenship. Furthermore, such experiments definitely deny the accusation of many social economists who are claiming that the medical profession is giving no thought to, nor attempting to solve the problem of the unpredictable, indeterminable cost of illness.

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CHARLES A. DUKES, M. D. (426 Seventeenth Street, Oakland).—The indigent, the near-indigent, and the patient who can pay a reasonable sum for medical and hospital care is the usual problem for every county in the care of the sick. When periods of depression appear the division between the indigent and near-indigent becomes very narrow.

I am doubtful of the wisdom of establishing a fee bill for the near-indigent, believing it is better to ascertain the financial status of each case and make the fee accordingly.

The distribution of the patients must be fair, and probably can be carried out geographically and alphabetically to the satisfaction of all. In Alameda County this plan of distribution of cases is being used.

Would it not be well to avoid the use of the title "Part-Pay Plan" and substitute "Medical Service" for work done for people of limited means?

FRACTURES OF BOTH BONES OF THE ARM OR LEG—THEIR MANAGEMENT*

By E. W. CLEARY, M.D.
San Francisco

DISCUSSION *by Arthur L. Fisher, M. D., San Francisco; Harold E. Crowe, M. D., Los Angeles; H. W. Spiers, M. D., Los Angeles.*

THE object of this paper is to discuss fractures of the forearm and leg bones from the viewpoint of the application of traction, and to present certain mechanical devices which have been found helpful in caring for such fractures.

The fracture problem has changed since the machine-age reached its heyday. The automobile has been characterized the greatest killer that man has yet invented. By the same token it leads the field in shattering, tearing, pulping and excessively contaminated injuries to the arms and legs. Such severe injuries are now produced at every corner and crossroads, and in the remotest regions where the automobile goes.

Changes in a problem predicate changes in methods for its solution. Every doctor now needs effective fracture equipment, which must include mechanical devices for traction and immobilization.

Certainly many cases of fracture may be effectively treated without the use of such mechanical devices, and should be so treated. The simplest effective method remains the method of choice. Some may deprecate the suggestion that an average doctor in an ordinary environment should use transfixion wire traction methods. It would appear, however, that the wide use of such methods, though not without hazard, would, on the whole, be less dangerous to the patient with severe complicated fractures, than the alternative of delayed or ineffective treatment.

IMPORTANCE OF EARLY REDUCTION AND EFFECTIVE IMMOBILIZATION

Reduction and effective immobilization at the earliest possible moment, particularly of compound or extensively comminuted fractures, are of signal importance. It was the French who, during the World War, emphasized the importance of early attention to dirty wounds by characterizing the first ten hours following the injury as the period of contamination, and the succeeding interval as the period of infection. Special effort should be made to complete cleansing, reduction and immobilization of compound fractures within the period before active infection has begun. Many, thus treated, get well with only an insignificant local reaction. Simple, easily available devices help to shorten the period of adjustment of the fracture, and to start it securely on the road to recovery before valuable time has been lost.

TRACTION IS INDISPENSABLE

Traction, in some form or other, is indispensable. Other things being equal, effectiveness of traction depends upon the method of application. Manual traction is sharply limited, is inexact and inconstant. Surface traction by means of mechanical devices is a step in advance sufficient to meet many needs. Maximum control and precision are attained by skeletal traction where the force is applied directly to bone at the points of traction and countertraction, and when both these points are hooked up to a rigid base of support.

The number and variety of rigid base traction devices is legion. Many new machines have recently appeared. Complexity and expensiveness tend to defeat the purpose of most of them. The desideratum is effective and inexpensive machines, convenient to carry and easy to set up, without elaborate mechanisms to get out of order; machines that are light and that get in the doctor's and the patient's way as little as may be.

* Read before the General Surgery Section of the California Medical Association at the sixty-fourth annual session, Yosemite National Park, May 13-16, 1935.

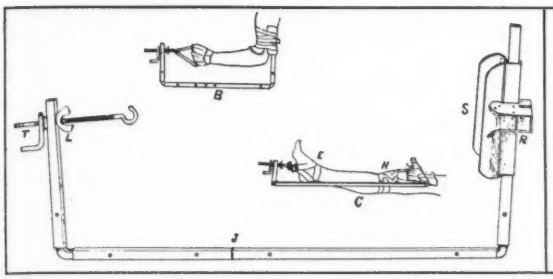


Fig. 1

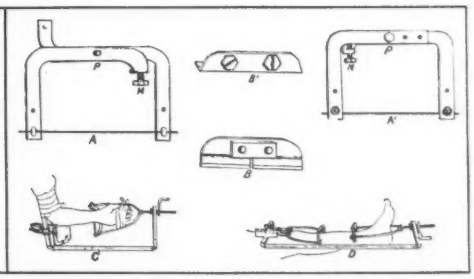


Fig. 2

Fig. 1.—Traction bar assembly; *S*, shield plate, reversible by use of bar channel *R*, for leg fractures; *T*, traction screw, lock nut *L*, when tightened, holds desired rotation; *B*, applied for closed reduction of forearm fracture—short adhesive holds hand closed; *C*, closed reduction leg fracture; *E*, ankle strap removable from under cast; *H*, knee strap.

Fig. 2.—*A*, self-tensing stirrups; *A'* hinge on bolt *P* and tense wire by tightening screw *M*; *BB'* retaining clamp, put on each end of wire; outside cast made snug to cast by bits of wet plaster bandage; stirrups off when cast hardens; *C*, transfixion wire traction on forearm; *D*, on the leg; bar not in the way of fluoroscopy; traction may be applied during operation. Entire assembly easily sterilized for operating.

AUTHOR'S TRACTION BAR AND TRACTION FRAME

Seeking such efficiency led the writer to devise a traction bar and a traction frame with some simple accessories. The previously devised appliances of so many men formed the background of the writer's efforts that it is not practicable in this limited time and space to mention their names. As the traction bar has been fully described in an article in CALIFORNIA AND WESTERN MEDICINE for May, 1935, and as the frame has been illustrated and discussed in the April, 1935 number of the *Journal of Bone and Joint Surgery*, detailed description of these devices will be omitted here.

Traction Bar and Its Application for Closed Reductions.—This traction bar and its application for closed reductions is shown in Fig. 1. Through its use powerful traction may be temporarily applied. It holds the reduced fracture, while affording accessibility for fluoroscopy and for the application of plaster or other immobilizing splint. Short adhesive straps, holding the fingers flexed, are easily removed after plaster has been applied distally down to the wrist. The special ankle and knee straps will slip from under the ends of plaster extended far enough to temporarily hold the fractures. Plaster is extended proximally and distally after removal of these traction straps.

This bar may be hooked up for transfixion wire traction through self-tensing stirrups with bridles as shown in Fig. 2. After fluoroscopy or x-ray to check reduction, plaster should be applied, the wires supported in tension against the cast by clamps, and the bar and stirrups removed. The wire retaining clamp is a rectangular steel plate, 3/4 inch by 2 inches by 3/16 inch thick, slotted for the wire and provided with a wire-locking screw. The use of such clamps widely extends the field of usefulness of small transfixion wire because the clamps hold the wire under tension in the cast. We are all aware, I trust, of the limitations of fracture operating tables which do not put control of traction and rotation in the hands of the surgeon in his field of operation.

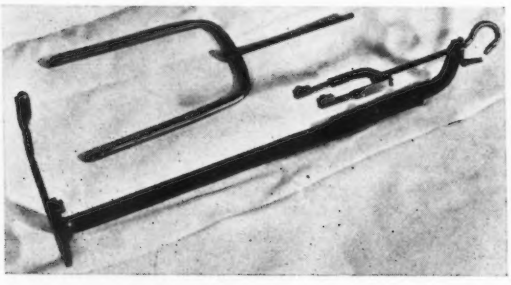


Fig. 3.—Special small traction bar and stirrups adapted for traction during operations.

The very small light traction bar, Fig. 3, is adapted for traction during operation only. It is useful when doing open reductions, correction of deformities or grafts for malunions. The device brings control of traction and rotation completely within the aseptic field of operation. It has also been helpful in open reductions of badly comminuted and displaced supracondylar fractures of the humerus involving the elbow joint. Special tension on wires is unnecessary for temporary traction during operation, provided stirrups of narrow span are used. The precision with which a fracture may be held by transfixion wires hooked up to this small bar is in pleasing contrast to the clumsiness and uncertainty of bone-holding or grasping forceps.

Traction Frame for More Difficult Fractures.—For the care of the most difficult fractures, the traction frame shown in Fig. 4 provides the desired mechanical aid, and does not get in the way so much or hit the pocketbook so hard as the heavier and more elaborate devices. Every range of adjustment in length, angulation or rotation that a fracture frame can deliver, using one wire for traction and another for countertraction, is practicable using this device. A high degree of lightness and adaptability has been obtained by using the simplest form of horseshoe stirrups, and making the proximal stirrup a part of the frame. The compression tongs, used to compress

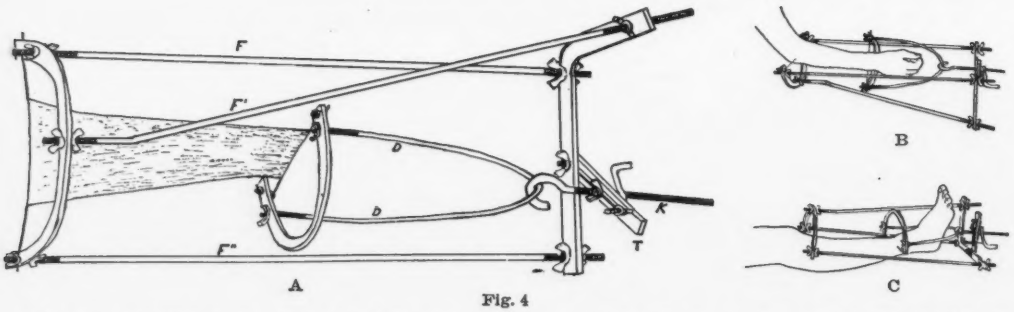


Fig. 4

Fig. 4.—*A*, traction frame. Note possibilities for adjustment: (1) At either ends of bars *F*, *F'*, *F"* and bridle *D*. (2) Radial and vertical by slotted post *T*. (3) Rotation by traction screw *K*. *B*, frame applied to fractures of forearm. *C*, frame applied to fractures of the leg.

the stirrup before hooking up to the wire, are shown in Fig. 5.

No two-wire system can completely control the distorting tendencies of unbalanced muscular and ligamentous stresses. When angulation due to such causes is discovered after a cast has been applied incorporating the transfixion wires under tension, the alignment is usually easy to correct either by simple wedging of the cast or by the use of a turnbuckle. Once only in the writer's experience, following wedging a cast three weeks after the wires had been put in, infection occurred at one end of one wire. In my opinion the change in stress on that wire allowed superficial infection on the surface to penetrate into the bone along the wire channel. Since this experience, we have avoided making any radical change in stress upon any wire that has been in place for any considerable time.

Use in Forearm Cases.—In forearm cases the proximal wire is usually put through the ulna about an inch below the tip of the olecranon. The lower wire enters the radius at a point at the junction of the flexor and radial surfaces about one and one-half inches proximal to the tip of the radial styloid, and is directed so as to emerge on the dorsal surface near the ulnar shaft. It does not interfere at all with rotation. The points of insertion and emergence are dressed with very small gauze squares slipped over the wires.

Fracture of Both Bones of the Forearm.—A fracture of both bones of the forearm, which was brought to the author ten days after injury, after the failure of many attempts at closed reduction and final failure of an elaborate effort at nonskeletal traction, is shown in Fig. 6. This fracture was reduced in the traction frame. The result is shown in Fig. 7.

Wire is much less likely to cause infection or ring sequestration than a large pin. Transfixion wire, which is too small, breaks. In one instance, .054 wire held for nearly eight weeks but broke before removal.

We now use .0625 oil-tempered spring steel wire and have had no trouble with breaking. Wires are cut from the stock of oil-tempered spring steel, using a Scholhorn type, compound leverage wire-cutting plier. A few strokes with a fine mill file provide a three-faceted trocar point which penetrates the hardest bone easily. A light mechanic's drill has been adapted for wires by extending the hole through the chuck and handle. No guide has been found necessary. Wire clamps, which hold the wire under tension against a cast, have greatly increased the adaptability of small transfixion wire.

IN CONCLUSION

It has been the intent to show that these simple mechanical devices for traction can be of great assistance in both closed and open reductions, and to, in a measure, "debunk" the idea that elaborate and expensive appliances are essential to transfixion wire traction. It is believed that

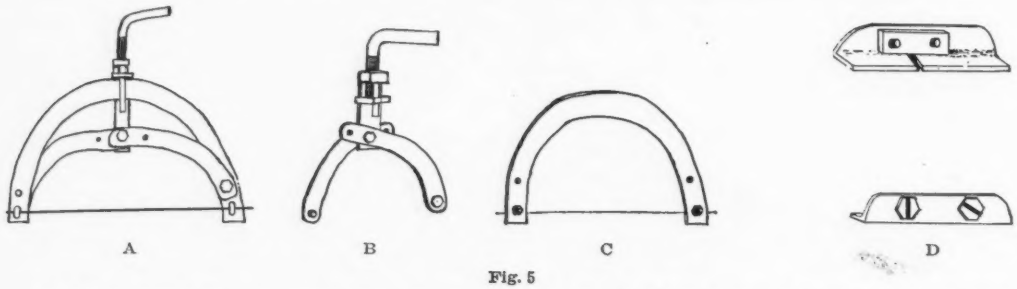


Fig. 5

Fig. 5.*—*A*, stirrup and compressor tongs. *B*, compressor tongs. *C*, stirrup tightened on wire, tongs removed. *D*, retaining clamp. After cast is on, a clamp is put on either end of each wire. Small bits of plaster bandage are used to make snug the bearing surface of clamp on cast. Stirrups may be removed as soon as cast hardens.

* The improved retaining clamp is not illustrated.

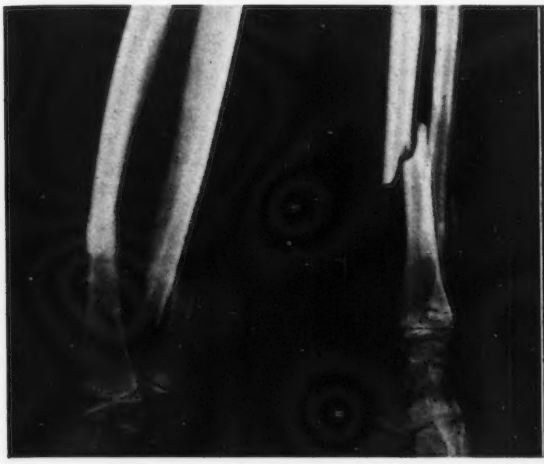


Fig. 6.—Fractures of forearm bones, ten days' duration, after repeated failure to secure reduction.

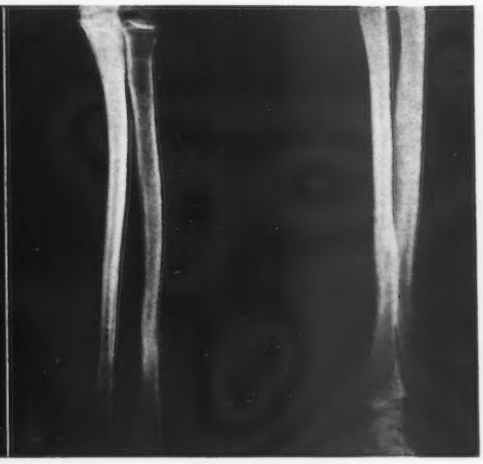


Fig. 7.—Result after reduction in the traction frame.

this effort is justifiable because difficult fracture problems occur wherever there are doctors, and because many doctors have been deterred from providing themselves with effective equipment due to expense, elaboration and mysterious difficulties which have been supposed to be attendant upon the use of skeletal traction, and particularly of small transfixion wire under tension.

The necessity for the exercise of discrimination and judgment in using skeletal traction is not minimized. Introduction of even the smallest wire compounds the fracture at that point, and the writer believes that no fracture should be compounded if it can be effectively dealt with by closed reduction. It is gratifying, therefore, in discussing skeletal traction at such length, to have presented also a device (the traction bar, Fig. 1) for facilitating closed reductions.

The devices presented have been a matter of gradual development and have undergone many changes. Doubtless they are still amenable to much improvement. Having found them helpful we hope that some others may find them worthwhile.

490 Post Street.

DISCUSSION

ARTHUR L. FISHER, M. D. (2000 Van Ness Avenue, San Francisco).—Whenever and wherever traction is necessary, the simpler the device the better. This apparatus of Doctor Cleary's is simple and has several features that seem to me to add to its utility. I was particularly struck by the bar that controls supination and pronation in cases of forearm fracture. This, I think, is a very great advantage. Many forearm and elbow fractures may be set with due regard to the position of the bones themselves, *i. e.*, getting end-on apposition, but with no regard paid to supination and pronation. In such cases frequently there is a pronation contracture by the time the fracture is healed.

I am not one of those who feel that every patient who has a fracture must be transfixed with pins in order that the fracture be well set. I think that at the present time there is too much transfixion of bones by means of pins, etc., and that too many surgeons take liberties with other people's bones.

There are instances, however, when this type of treatment is absolutely essential, and I think that this apparatus devised by Doctor Cleary is as good as any and, particularly for forearm fractures, is better than most devised. Its advantages consist in its lightness, its ease of applicability, and the facility with which changes in position can be made.

❊

HAROLD E. CROWE, M. D. (2417 South Hope Street, Los Angeles).—It is a pleasure to discuss Doctor Cleary's paper regarding skeletal traction: first, because he has succeeded in simplifying and reducing the cost of apparatus for the application of transfixion-wire traction, and, second, because he has so generously admitted that this field should be open to the medical man faced with a difficult fracture, even though he may be located at the crossroads and not accustomed to call himself a specialist in bone surgery.

Experience with transfixion-wire traction has led me to believe that the introduction of wires is almost comparable to giving a hypodermic injection, since I have seen remarkably gross errors made while attempts at pin traction were in progress, without any unfortunate results. For instance, on several occasions as an attempt was made to introduce a wire through the distal end of the radius, I have seen the wire slip off the bone and shoot rapidly through the soft tissues of the wrist, where the multiplicity of tendon, nerve and blood-vessel structures is undoubtedly the uppermost thought in one's mind at such a time. None of these accidents have ever given any permanent injury or loss of function.

I feel that Doctor Cleary's suggestions are a definite contribution to the better general treatment of severe fractures.

❊

H. W. SPIERS, M. D. (614 Westlake Professional Building, Los Angeles).—The successful modern treatment of fractures of the forearm and lower leg requires accurate knowledge of the use of skeletal traction and countertraction. The value of skeletal methods of traction in these regions has only lately been widely appreciated. Numerous complicated pieces of apparatus are now being evaluated. Doctor Cleary's ingenious apparatus recommends itself because of its simplicity.

The fundamentals of fracture surgery are: First, reduce by traction and countertraction; second, place the distal fragment in line with the proximal fragment; and third, immobilize. The apparatus that Doctor Cleary has devised fulfills these fundamentals in an unusually simple manner.

One danger, I feel, should be emphasized. Methods of skeletal traction are not for the use of the tyro. Thorough knowledge of their use, abuse, and dangers are essentially for their successful application. Skeletal traction does not

in itself reduce the fracture. It is the skill of the surgeon that reduces the fracture. This fact should not be lost sight of in any discussion of this subject.

❋

Doctor Cleary (Closing).—I would like to say a further word about the selection of transfixion wire. I am not committed to the use of ordinary oil-tempered spring-steel wire, although we have found this metal practicable and effective for the average case. Some of the stainless-steel wires, while more expensive and not so easily handled in penetrating the bone, will not snap as the tempered wire sometimes does. I feel that the wire should be selected according to the magnitude and duration of the stress that it is expected to carry.

Doctors Fisher and Spiers have emphasized the technical and the limited application of skeletal traction. May we not fully agree with them, and yet face clearly the fact that modern conditions bring serious fracture problems with increasing frequency to a single ordinary doctor, who must assume the responsibility for treating the injury with which he is confronted. I believe that "be prepared" is a better sentiment for us to leave with a colleague who may face such a situation than "beware meddling."

SHOCK TREATED BY WARMED AIR

By Harold H. Hitchcock, M.D.
AND
T. Eric Reynolds, M.D.
Oakland

Discussion *by Edmund Butler, M.D., San Francisco; C. D. Leake, Ph.D., San Francisco.*

MANY useful inventions have come as a result of men with an inventive turn of mind getting into trouble. This is just as true in the field of medicine as with inventions in general. The apparatus which we wish to report came about in just such a way. The inventor was lying in bed in a rather extensive cast, which he found to be uncomfortable while it was drying. After he recovered, remembering his own experiences, he sought about for a method of facilitating drying and cutting down the degree and duration of such discomfort. The Sweetland cast-dryer is the result of that effort.

The apparatus consists, essentially, of a cabinet with electrical coils for heating, together with a blower which delivers this warmed air into flexible tubes (Fig. 1). These tubes fit, by means of simple coupling devices, into a coiled spring mat which can be laid on a bed or folded around a patient, as any ordinary blanket or mat would be (Fig. 2). The coiled springs are covered by fabric, which makes the whole unit into a flexible chamber or a flexible hollow wrapping, through which the heated air circulates, to leave by a vent at its distal end. The principal mat, which envelopes the body and legs, is augmented by an auxiliary mat, which can be fitted over an arm to which a separate pipe can deliver heated air. The amount of heat delivered is subject to simple regulation by means of switches, so that a greater or lesser degree of heat can be obtained, depending on the needs. This device is the invention of Mr. E. J. Sweetland, and it proved highly satisfactory for its original purpose as a cast-dryer.

Its success in alleviating the distress of a drying cast prompted us to extend its use to the treatment of patients in surgical and traumatic shock, irrespective of whether or not they were provided with a cast. An early opportunity came in an individual who presented a combined picture in that he developed shock soon after an operation for bone graft of the femur for an ununited compound fracture. While the other measures to combat shock were being put into operation, he was encased in a cast-dryer, which, in addition to helping his rather extensive cast to dry speedily, also provided him with quick, generalized heat. This is an important factor in recovery from shock.

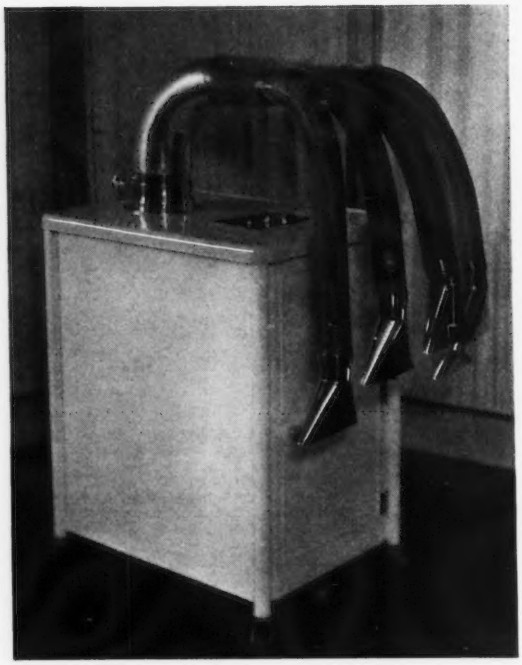


Fig. 1.—Warm air blower with flexible tubes.

Subsequently, the Sweetland apparatus was used by ourselves and our colleagues on various types of shock, including postpartum, postoperative, and posttraumatic shock. We have extended its use now to the prophylaxis of this condition by using the "cast dryer" whenever we have any reason to



Fig. 2.—The cast is encircled by the mat.



Fig. 3.—Assembly view of whole apparatus.

anticipate the possibility of shock. It is laid out in the patient's bed before he returns to it from surgery, and the bed is previously warmed thereby. As soon as the patient is in bed, it is used with the ordinary coverings and a moderate degree of heat kept up as long as necessary. It also subserves a very useful purpose in the treatment of individuals who are admitted into receiving and general hospitals in a state of shock from traffic and other accidents, as they can thus be warmed up in bed while an accurate diagnosis is being made.

1624 Franklin Street.

DISCUSSION

EDMUND BUTLER, M. D. (490 Post Street, San Francisco).—The Sweetland cast-drier gives promise of being an excellent method of administering controlled heat. First, used as a bed warmer it must be very efficient. Not alone are one or two local areas heated by hot-water bags, as is the usual procedure, but the entire covering and the mattress would be thoroughly warmed. This, I feel, is a distinct advantage. Secondly, used as a means of administering heat to the patient, this again is most advantageous; but I am of the opinion that it must be controlled very carefully, and not too great or prolonged a temperature produced. A very severe type of shock may be the result of continued high temperature.

I wish to thank Doctors Hitchcock and Reynolds for bringing this method of heat administration to our attention.

❋

C. D. LEAKE, Ph.D. (University of California Medical School, San Francisco).—Evidence exists that "shock" is related to outpouring of adrenin and subsequent exhaustion of the adrenals (P. K. Knoefel, Calif. and West. Med., 39:344, 1933). This offers a probable explanation of the fall in temperature in "shock." Sparing the adrenals by supplying heat in this situation is thus rationalized, and certainly experience has abundantly justified the procedure. The method of providing heat described by Doctors Hitchcock and Reynolds is an ingenious, easily controllable, and highly effective one. Its use, as so succinctly indicated by them, should be very helpful, especially when available for emergencies.

BIOPSY IN MALIGNANT DISEASE*

By OTTO H. PFLUEGER, M.D.
AND
W. P. STOWE, M.D.
San Francisco

DISCUSSION *by Emile Holman, M.D., San Francisco; Orville N. Meland, M.D., Los Angeles; George S. Sharp, M.D., Pasadena.*

AS a result of intensive propaganda by the medical profession, patients with malignant disease are presenting themselves for care earlier than in past years. We are seeing, therefore, many more lumps of the breast, neck, subcutaneous tissue, etc., than we did, in which the diagnosis is neither obvious nor easy to make without direct examination of the entire tumor or a portion of it. Furthermore, even though one may make a correct clinical diagnosis, it is desirable to know the type of tumor with which one is dealing—its histologic picture, its probable response to irradiation, and its likelihood of recurrence. These things are important, and all available knowledge should be had concerning a tumor before treatment is undertaken. Pathologic examination is also necessary for the completion of our records, for only by such means can we evaluate any form of treatment three to five years later. This is especially true in those cases in which surgery is not contemplated and treatment is entirely by irradiation.

We feel, therefore, that a short discussion of the question of biopsy will not be amiss before this section of men who are largely responsible for the obtaining of tissue for examination. A knowledge of the indications and contraindications, and of the correct technique for obtaining a biopsy specimen, is of great practical importance in the treatment as well as in the diagnosis of malignant conditions.

We are not concerned in this paper with the procuring of a specimen from an ulcerated surface lesion. One can remove a small portion of tissue from the edge of such a lesion with a biopsy forceps with a reasonable assurance that no harm is being done. By means of an endotherm loop one has the possible added safety of control of hemorrhage and the questionable sealing of lymphatics. If this instrument is lacking, one need not, however, hesitate in taking a small piece from the edge in the ordinary manner, with as little trauma as possible.

DETERMINING THE NATURE OF THE TUMOR

What does concern us is how, with the least possible harm to the patient, we are to determine the nature of a tumor which arises beneath the surface of an unbroken skin. Properly performed, such biopsy will not decrease the patient's chance of cure, and will aid in outlining proper treatment. Three methods are available in cases of this type:

* From St. Luke's Hospital and the University of California Surgical Service of the San Francisco Hospital.
Read before the General Surgery Section of the California Medical Association at the sixty-fourth annual session, Yosemite National Park, May 13 to 16, 1935.

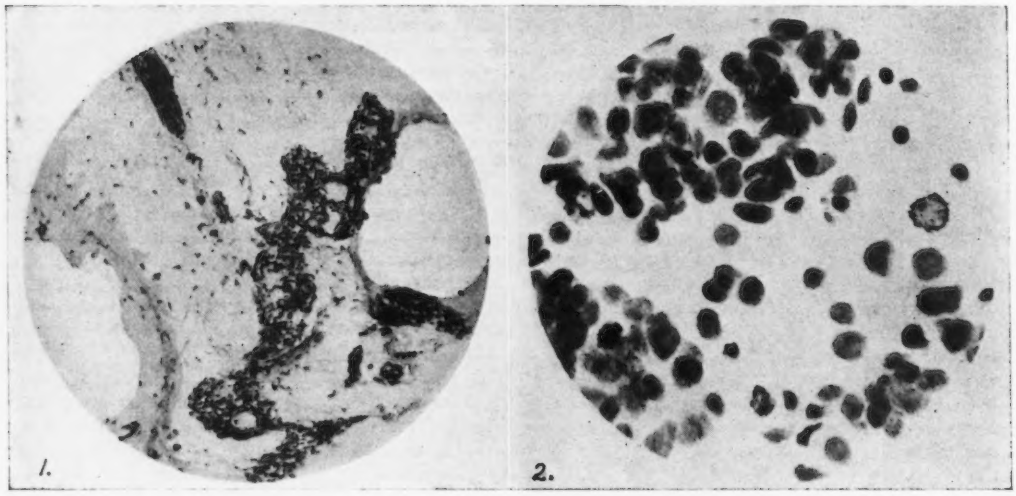


Fig. 1 Fig. 2

Fig. 1.—Mixed tumor of parotid x 125. Loose myxoma tissue with nests of epithelial cells.
Fig. 2.—Carcinoma of parotid x 640. Irregularity of cell size and shape with three mitotic figures.

1. Incision directly into the tumor for observation of gross tissue, or removal of a portion for microscopic study.

2. Removal of the entire lump with a wide margin of normal tissue.

3. Aspiration of a small bit of tissue through an ordinary needle. With the last, one might mention such special instruments as the Hoffman punch,[1] but the mere simplicity of ordinary needle puncture and aspiration, requiring no unusual equipment, makes it the most readily available for this type of biopsy.

INCISION INTO THE TUMOR

Incision into a tumor, to observe its gross appearance or to procure a specimen, is undesirable and should be avoided when possible, because tumor cells may be implanted into normal tissue and a large number of blood and lymph channels are opened. Ewing especially feels that incision into a tumor alters the clinical setting by breaking down the natural local barriers, and favors early metastasis. The introduction of infection into a tumor, and the fungation of tumor tissue through the wound in the skin, are other possible complications. The latter is especially so in growths where the tumor tissue is under tension either because of the nature of the tumor—as in myxomas—or because of secondary necrosis. Bone tumors, also, are especially likely to fungate through a biopsy incision. Probably nothing which may occur in the course of a tumor's growth so alters

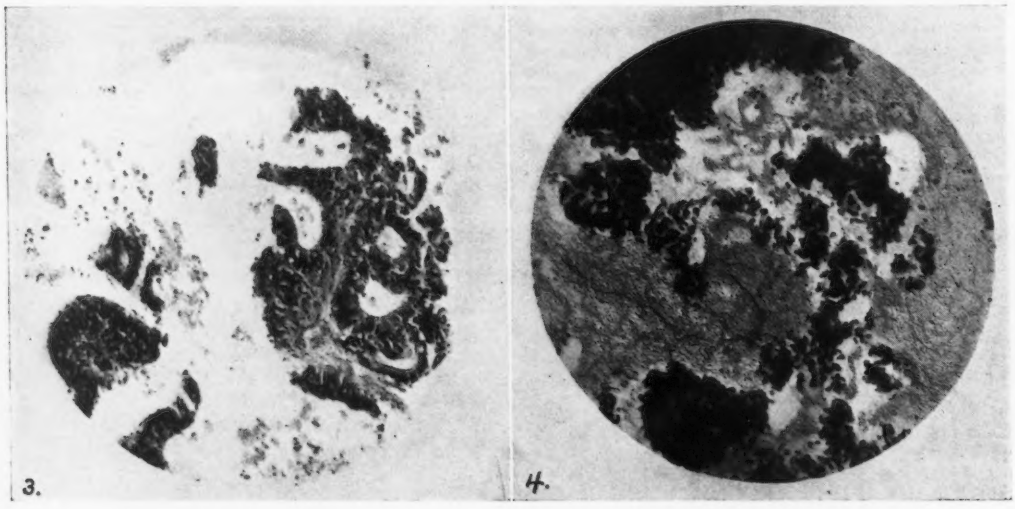


Fig. 3 Fig. 4

Fig. 3.—Rib metastasis from adenocarcinoma of large bowel x 125. Paraffin section.
Fig. 4.—Same of stained crushed specimen.

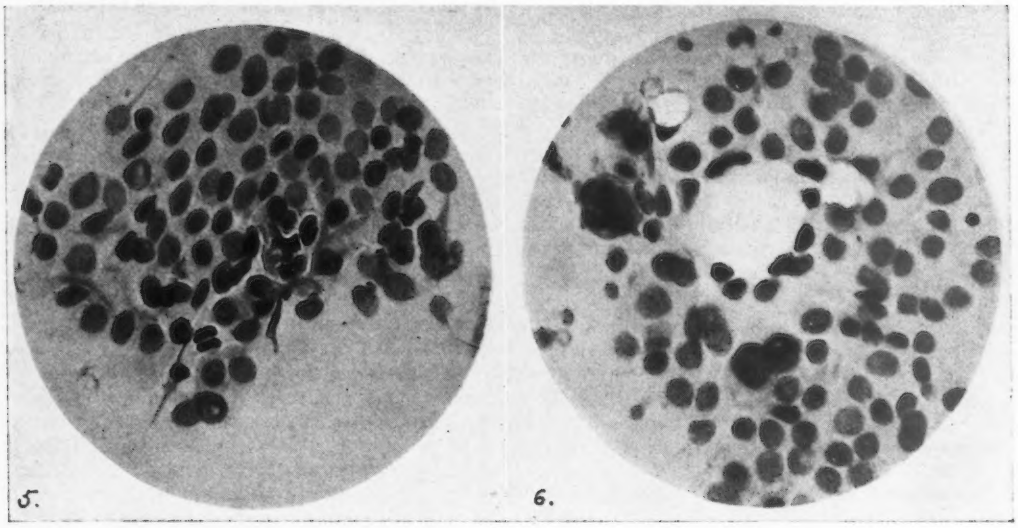


Fig. 5 Fig. 6

Fig. 5.—Intracanalicular fibro-adenoma of breast x 640. Uniformity of cell pattern.
Fig. 6.—Adenocarcinoma of breast x 640. Shows irregular cell and nuclear size and pattern. One cell with four large hyperchromatic nuclei; one with two.

its clinical picture, and behavior and response to treatment, as does infection. Scrupulous care is needed to avoid it.

There are, however, instances when incision into the tumor for diagnosis is necessary. When this is so, a definite routine should be planned beforehand. Facilities for immediate diagnosis should be available, and the treatment indicated carried out at once. While we are not concerned here with treatment, the procedure of biopsy cannot be divorced from it. For instance, many surgeons transect a tumor of the breast to observe the cut surface for diagnosis. If carcinoma, the radical operation should be performed at once, after cauterization of the wound, and change of drapes, gloves, and instruments. It is a safer procedure to excise the lump widely, not cutting into it until it has been entirely removed. In biopsies of bone tumors everything should be ready for radical operation immediately if indicated. If a frozen section diagnosis at the operating table is not possible, the wound should be carefully closed, and x-ray treatment given in the interval it takes to arrive at a definite diagnosis. The Bone Sarcoma Registry contains cases well after five years in which some days elapsed after biopsy before radical treatment was instituted.

For perfectly obvious reasons biopsy is always indicated for confirmation of clinical diagnosis before such a radical procedure as amputation is undertaken. Such biopsy should be preceded by irradiation. X-ray treatment should also precede biopsy on soft tissue tumors to reduce the likelihood of metastasis, and to observe the effect of irradiation. In large lymph-node tumors, such as Hodgkin's disease or lymphosarcoma, it is preferable to take for biopsy a free node at the side of the bulky tumor, even though this gland may not always show a complete picture of the process. Where interstitial irradiation—that is, conservative treatment of metastatic glands—is the practice, the nodes may be exposed, a biopsy taken, and radon seeds or element needles immediately inserted into the gland which makes a good holder for the needles. Indiscriminate cutting into any lump which one may find is poor surgery, and poor cancer treatment, and should be condemned.

EXCISION OF TUMOR

Wide excision of a tumor for histologic examination is the procedure of choice whenever possible. This may not be feasible nor possible in large tumors. We prefer local excision of a small lump in the breast to incision into it. The Cancer Commission of the California Medical Association,[2] in its report on breast tumors, recommends local removal of a doubtful tumor, unless cancer is obvious at the first approach. To be sure, rough handling of the tumor and surrounding tissues may make for the situation we are trying to avoid, namely, the spreading of the disease, but all of us are aware of the delicacy that must be employed in the surgery of any neoplastic tissue. This procedure is of advantage also in that it yields the whole tumor for examination. Another reason for preference of local excision is that if the tumor proves to be benign, the operation has been completed and one need only close the wound.

There is another field where wide local excision is not only feasible but urged upon you, and that is in the case of the small subcutaneous tumor. The serious nature of these tumors is frequently overlooked. Many are sarcomata, and it is possible only by examination of the tissue under the microscope to distinguish between the benign

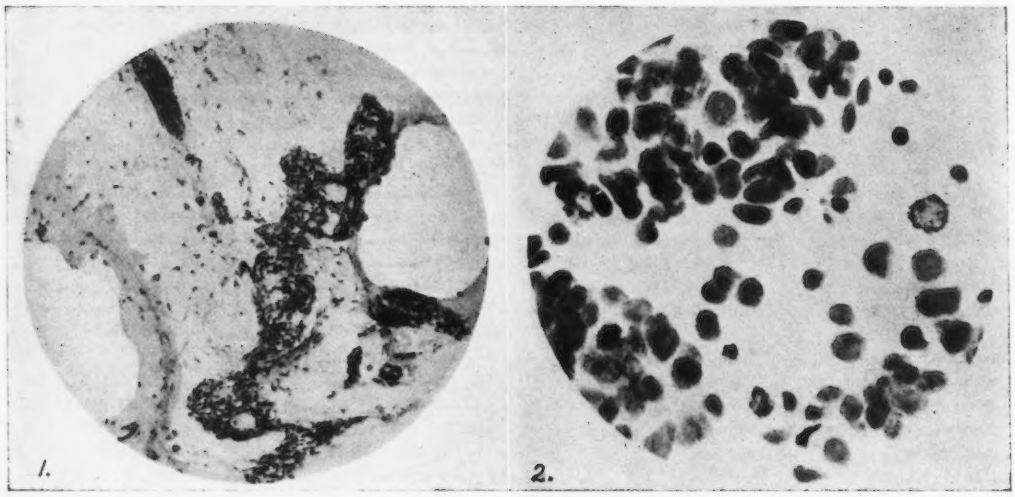


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3. Aspiration of a small bit of tissue through an ordinary needle. With the last, one might mention such special instruments as the Hoffman punch,[1] but the mere simplicity of ordinary needle puncture and aspiration, requiring no unusual equipment, makes it the most readily available for this type of biopsy.

INCISION INTO THE TUMOR

Incision into a tumor, to observe its gross appearance or to procure a specimen, is undesirable and should be avoided when possible, because tumor cells may be implanted into normal tissue and a large number of blood and lymph channels are opened. Ewing especially feels that incision into a tumor alters the clinical setting by breaking down the natural local barriers, and favors early metastasis. The introduction of infection into a tumor, and the fungation of tumor tissue through the wound in the skin, are other possible complications. The latter is especially so in growths where the tumor tissue is under tension either because of the nature of the tumor—as in myxomas—or because of secondary necrosis. Bone tumors, also, are especially likely to fungate through a biopsy incision. Probably nothing which may occur in the course of a tumor's growth so alters

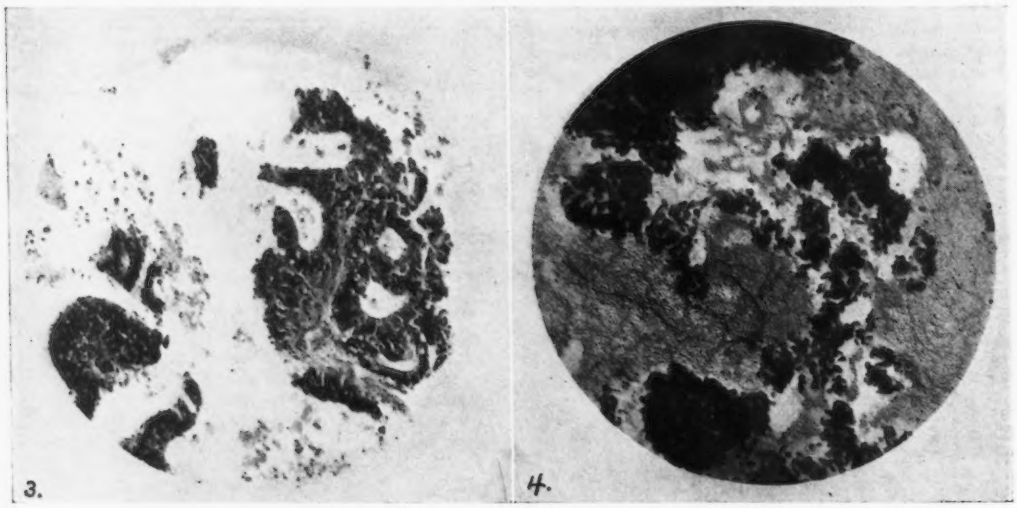


Fig. 3 Fig. 4

Fig. 3.—Rib metastasis from adenocarcinoma of large bowel x 125. Paraffin section.
Fig. 4.—Same of stained crushed specimen.

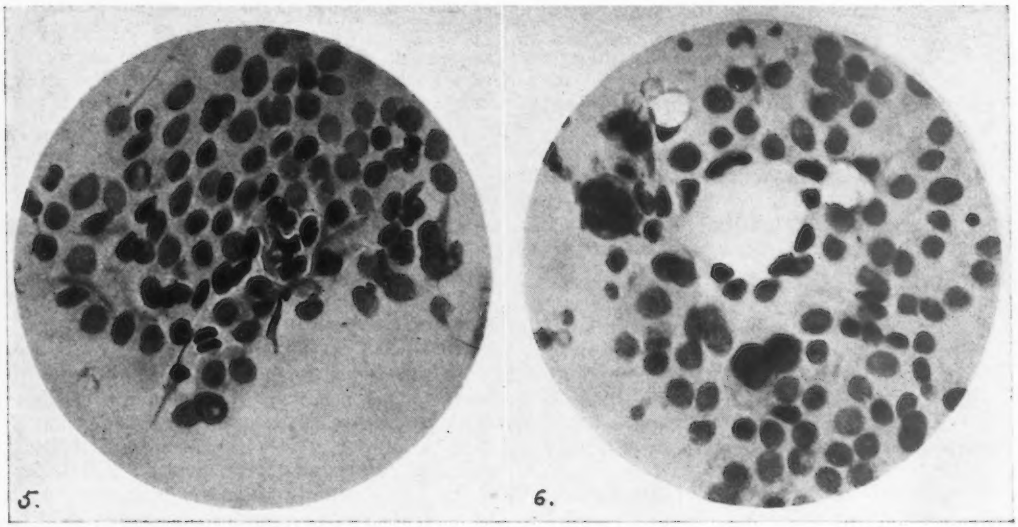


Fig. 5 Fig. 6

Fig. 5.—Intracanalicular fibro-adenoma of breast x 640. Uniformity of cell pattern.
Fig. 6.—Adenocarcinoma of breast x 640. Shows irregular cell and nuclear size and pattern. One cell with four large hyperchromatic nuclei; one with two.

its clinical picture, and behavior and response to treatment, as does infection. Scrupulous care is needed to avoid it.

There are, however, instances when incision into the tumor for diagnosis is necessary. When this is so, a definite routine should be planned beforehand. Facilities for immediate diagnosis should be available, and the treatment indicated carried out at once. While we are not concerned here with treatment, the procedure of biopsy cannot be divorced from it. For instance, many surgeons transect a tumor of the breast to observe the cut surface for diagnosis. If carcinoma, the radical operation should be performed at once, after cauterization of the wound, and change of drapes, gloves, and instruments. It is a safer procedure to excise the lump widely, not cutting into it until it has been entirely removed. In biopsies of bone tumors everything should be ready for radical operation immediately if indicated. If a frozen section diagnosis at the operating table is not possible, the wound should be carefully closed, and x-ray treatment given in the interval it takes to arrive at a definite diagnosis. The Bone Sarcoma Registry contains cases well after five years in which some days elapsed after biopsy before radical treatment was instituted.

For perfectly obvious reasons biopsy is always indicated for confirmation of clinical diagnosis before such a radical procedure as amputation is undertaken. Such biopsy should be preceded by irradiation. X-ray treatment should also precede biopsy on soft tissue tumors to reduce the likelihood of metastasis, and to observe the effect of irradiation. In large lymph-node tumors, such as Hodgkin's disease or lymphosarcoma, it is preferable to take for biopsy a free node at the side of the bulky tumor, even though this gland may not always show a complete picture of the process. Where interstitial irradiation—that is, conservative treatment of metastatic glands—is the practice, the nodes may be exposed, a biopsy taken, and radon seeds or element needles immediately inserted into the gland which makes a good holder for the needles. Indiscriminate cutting into any lump which one may find is poor surgery, and poor cancer treatment, and should be condemned.

EXCISION OF TUMOR

Wide excision of a tumor for histologic examination is the procedure of choice whenever possible. This may not be feasible nor possible in large tumors. We prefer local excision of a small lump in the breast to incision into it. The Cancer Commission of the California Medical Association,[2] in its report on breast tumors, recommends local removal of a doubtful tumor, unless cancer is obvious at the first approach. To be sure, rough handling of the tumor and surrounding tissues may make for the situation we are trying to avoid, namely, the spreading of the disease, but all of us are aware of the delicacy that must be employed in the surgery of any neoplastic tissue. This procedure is of advantage also in that it yields the whole tumor for examination. Another reason for preference of local excision is that if the tumor proves to be benign, the operation has been completed and one need only close the wound.

There is another field where wide local excision is not only feasible but urged upon you, and that is in the case of the small subcutaneous tumor. The serious nature of these tumors is frequently overlooked. Many are sarcomata, and it is possible only by examination of the tissue under the microscope to distinguish between the benign

fibroma or neurofibroma and the small sarcoma. These small sarcomata are peculiarly prone to recur. To incise one for diagnosis is, therefore, foolhardy, and equally so is its simple enucleation. Wide removal constitutes adequate surgery, gives one the entire tumor for examination, and is a safer procedure. To quote from another report of the Cancer Commission:[3] "Biopsy for small lumps is condemned. Excision is safer, certain, and not more difficult, and lends itself to a more thorough study of the whole tumor microscopically."

ASPIRATION BIOPSY

We prefer aspiration of a tumor to incision into it, for the purpose of obtaining material for histologic examination. There is definite indication for it in those tumors beneath the skin where complete removal of the lump is not feasible for adequate reasons, and where, ordinarily, incisional biopsy is done. It should also be used in those cases where irradiation is the best method of treatment in order to give us a histologic record for evaluation of the treatment, at the same time avoiding a surgical procedure in the operating room in obtaining this tissue. Furthermore, irradiation has less effect upon a tumor which has been incised and where fibrosis is present. Aspiration avoids the necessity for incision, and its disadvantages.

The method is not new, but for some reason it has not been utilized to the fullest extent of its possibilities. Within recent years it has been used largely at Memorial Hospital in New York; and papers by Martin and Ellis,[4,5] Coley and Sharp,[6] Sharp,[7] and by Ferguson,[8] have shown its value in various clinical varieties of growths. Tumors of cervical nodes, metastatic and primary; parotid and submaxillary glands; intra-oral tumors with nonulcerated mucous membrane; breast, bone, thyroid, lung, prostate, and soft tissue, have been diagnosed by this method. Recently, Stewart,[9] at the same institution, has reported on the pathologic interpretation of the material so obtained in 2,500 cases. No untoward results were noted in any of the cases as a result of the procedure.

The method used to obtain the tissue is that recently fully described by Martin and Ellis [4] in their paper published in 1934. It consists briefly in advancing an 18-gauge needle, attached to a tightly fitting record syringe, into the tumor through a stab wound in the skin made after injection of a little novocain. After the needle has entered the tumor, negative pressure is made within the syringe, and this is maintained continuously until one is ready to withdraw the needle. The needle is advanced in the tumor, withdrawn the same distance, again advanced at a slightly different angle, withdrawn an equal distance; the vacuum in the syringe is slowly reduced; the syringe detached and the needle separately withdrawn. The material in the needle is ejected onto a slide, crushed between two slides, air-dried, slightly flame-fixed, and then flooded with absolute alcohol for about two minutes to fix more firmly to the slide. Then it is washed in water; stained with hematoxylin (our preference is five to ten minutes in Mayer's hemalum); washed; mordanted in tap water for five minutes and stepped up through eosin in 95 per cent alcohol; two changes of absolute alcohol; carbolyxlol; hylol; and mounted with Canada balsam.

Resultant cell groups are searched for with low power, and analyzed with high power for arrangement—often typical—hyperchromatism, atypical structure or architecture; cell irregularity in size or nuclear pattern, and mitotic or amitotic division figures. There must be kept in mind that the aspiration picture will overemphasize the softer and more cellular structures, the fibrotic, hard, resistant tissues being less included in the needle specimen.

At times, no tumor cells are present in the smear. This occurs if the technique is faulty; at times, with correct technique, if the tumor is hard and fibrous; or when the mass is cystic or inflammatory rather than neoplastic. One elderly woman had a large cystic tumor of the maxilla with pressure bone erosion, which was considered as a possible adamantinoma. The material aspirated showed no tumor cells, only pus and inflammatory cells. At operation a large, smooth, thick-walled cyst was easily removed, which on section was entirely inflammatory. Tuberculosis of cervical glands was diagnosed in another case, and in another a liver mass was found to be actinomycosis.

That aspiration biopsy has certain drawbacks, no one can deny. These lie chiefly in the finer pathologic interpretations. The various types of cancer of a particular organ usually cannot be differentiated, nor can one always grade a tumor and so determine its probable response to irradiation. Coarser differentiations, however, are possible. For instance, in material aspirated from cervical nodes one may see squamous pearls, or one may find the sheets of cells characteristic of the transitional cell type, and so know what type of treatment is indicated. We have so done in our own series, with the transitional type completely disappearing under x-ray treatment. What one is diagnosing is usually a smear of tissue, unless one obtains enough material for paraffin section. Cell relations are largely lost, as are the relations of the whole tumor to the surrounding tissue. But neither do we have this latter information when a small piece of tissue is removed through an incision, and that is what most surgical biopsies consist of.

It must be emphasized that the method is not one for academic detachment. The pathologist and the clinical surgeon must sit down together with their completed slides and consider all aspects of region and tissue involved, and the clinical aspects of the case. Then, out of their combined efforts they must try to formulate a diagnosis. Many times the resultant will be definite as to type and malignancy; many times definite as to malignancy, but not type, and many times it will be, in honesty, "indeterminate." In these cases no chagrin need be felt, as the patient has not been harmed and the traditional methods can then be employed.

The essential training in learning this method is to needle every routine tumor received in the laboratory and then compare these preparations with the tissue sections until some wisdom is attained in their interpretation.

Mention of a few locations in which aspiration is feasible and has helped us is probably the best way of demonstrating its value. It can be used in doubtful tumors of the breast. It is especially valuable in those cases which turn out to be cancer, because then the indicated treatment can be carried out with the least previous interference. If benign, the patient can be reassured with little loss of time. Also cases may be quite obviously cancer, but for some constitutional or other reason treatment must be entirely by irradiation. It is important to have histologic proof for record, which can be obtained very easily by aspiration. Bone tumors, especially liable to fungate through biopsy wounds, can be diagnosed as to their general nature by aspiration when the cortex is sufficiently eroded to allow penetration of the needle. The same applies to antrum tumors. Coley and Sharp[6] have reported success in aspiration of bone tumors in a high percentage of cases, occasionally having a diagnosis only of malignant tumor cells, but most often a definite diagnosis as to type.

The differential diagnosis of cervical tumors is frequently difficult, and especially so if no primary lesion is found to account for metastasis. The first indication of a large percentage of pharyngeal or tonsillar lesions is an enlargement of cervical glands. Aspiration will most often make the diagnosis of the condition in the nodes; at least it will give strong presumptive evidence as to the nature of the condition. Presumptive evidence is usually all that is possible in Hodgkin's disease and lymphosarcoma. We have repeatedly made correct diagnoses in cases of metastatic glands, and have at times ruled it out by finding an inflammatory condition. If necrotic material is obtained, it may be due to an inflammatory condition, such as tuberculosis, or to broken-down carcinoma. The latter occurs frequently if irradiation has been previously given, but one can usually find cells which are undoubtedly of a malignant nature. Aspiration is attended with much less interference than the removal of such a gland.

It is impossible to consider all types of tumors and locations in which aspiration is of value. As mentioned, it can be used in cases where an incision into the tumor would ordinarily be made. Reference to the figures will show some of the material we have obtained by aspiration, and the microscopic picture of the same.

CONCLUSIONS

1. To know the indications for biopsy is a need of every individual who treats neoplastic diseases.

2. Surgical incision into a tumor should be avoided, and can be avoided in most instances.

3. Wide excision of a tumor for diagnosis is the best means of obtaining tissue for examination whenever feasible.

4. Aspiration through needle puncture is a sensible means of biopsy, and will give a tissue diagnosis in most instances.

384 Post Street.

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DISCUSSION

EMILE HOLMAN, M. D. (Stanford University Medical School, San Francisco).—There can be no question that biopsy upon suspected malignant disease is more frequently necessary at the present time than in former days, when patients consulted a physician for cancerous lesions recognizable as such on inspection alone. In performing such biopsies it is most necessary to bear in mind the potential dangers inherent in the procedure. The division or rupture of blood and lymphatic vessels within a malignant tumor inevitably conditions the possibility of cancer cells being carried off into the blood or lymphatic systems to be deposited elsewhere beyond the surgeon's reach.

In the course of a recent operation for a questionably malignant tumor of the breast, the mass was transected and observed to be cancer; then the cut surfaces were cauterized with phenol and the incision closed. An immediate radical mastectomy was performed. Microscopic examination of the axillary nodes revealed whole fresh blood cells in the lymph sinuses within the glands. These undoubtedly had their origin from the cut surfaces of the first incision. The interval between the incision and the removal of the nodes was approximately sixty minutes. There is no reason why cancer cells could not be equally quickly transported from tumor to lymph sinus. The lesson is obvious. No biopsy should be undertaken that is not followed immediately by the proper treatment, whether it be surgery or radiation therapy.

Aspiration biopsy requires special training in the interpretation of the material obtained, and should not be undertaken unless such experience in interpretation has previously been available. Given the essential equipment and a properly trained pathologist, the aspiration biopsy should have a wider field of usefulness.

Transection of the tumor for inspection of the cut surface should be reserved only for lesions that are not easily enucleable. Where possible, complete excision of the tumor, as in small lesions of the breast, is the most desirable method of obtaining a specimen, the character of which will determine the subsequent course of the operation or treatment.

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ORVILLE N. MELAND, M. D. (1407 South Hope Street, Los Angeles).—Despite all our efforts in the refinements of diagnosis of tumors, we are still dependent upon biopsy.

In the final analysis, it is only by microscopic examination of the suspected tissue itself that one is able to make a definite diagnosis of a benign or a malignant condition. From a theoretical standpoint, there is always a possibility of dissemination when a biopsy is done, but the possible harm is much less than the good it accomplishes for the patient. However, when done, suitable treatment should be carried out immediately so as to lessen such a danger; this is especially true where the surgeon must cut through normal tissue to reach the suspected lesion.

Within the last few years the use of aspiration biopsy has come to the front. It is particularly useful where the treatment is to be radiological, rather than surgical; but even where surgery is contemplated after preoperative radiation, it is advisable, as it not only makes a definite diagnosis possible, but it acts as a guide in establishing some criterion as to the amount of therapy that should be given.

These are the advantages, but there are certain disadvantages also. When positive the method is excellent, but where the aspiration is negative it means little one way or the other. For instance, in suspected Hodgkin's and lymphosarcoma it is to be condemned, for even when an entire node is removed the pathologist may have difficulty in arriving at a correct conclusion; so, wherever feasible, the regulation method of biopsy is preferable.

It is very commendable of Doctor Pflueger to focus our attention on biopsy again. Whatever progress we hope to make in the early recognition of cancer must necessarily be along these lines. The method of doing a biopsy is of secondary interest; it is the interpretation of the tissue that is of paramount importance.

GEORGE S. SHARP, M. D. (605 Professional Building, Pasadena).—We have heard a complete treatise on the subject of biopsy, and only certain statements that Doctors Pflueger and Stowe have made need emphasis.

The preliminary working diagnosis should be based primarily on a thorough history and complete physical examination. Special examinations, such as transillumination, are important diagnostic procedures, and should always be performed when of advantage for the most accurate clinical impression. Information gained from the above examinations should enable the physician to determine the correct diagnosis in at least 85 per cent of the patients.

Pathological confirmation of the diagnosis is desirable many times before treatment is started, when the clinical findings are not definite. Frequently a radiation program is planned, or preoperative x-ray therapy is advisable, and a pathologic report is most necessary for the tissue structure and degree of anaplasia. The proper dosages of radiation must be based on this microscopic study.

The aspiration biopsy is of great value for the above material in certain cases. By this procedure, a tissue examination is possible without risk (Ewing, Stewart) and without loss of time and wound healing, and it is a procedure that may be performed without hospitalization or delay. The aspiration biopsy may be used for many ulcerated tumors. This procedure is used regularly for locating and identifying intracranial tumors. I have found the procedure of very definite value in identifying metastatic lymph nodes, tumors in the upper lobe of the lungs, or those located well out in the parenchyma, beyond the reach of the bronchoscope. Complete differentiation cannot always be made upon the smear, but the question of malignancy can be settled. This type of tissue study does not make it possible to differentiate between the different members of the lymphoblastoma group and Hodgkin's disease.

The reason for this discussion, I believe, is to condemn the hasty operation for diagnosis, and to replace it with a more complete and effective program which is based on the complete clinical findings (with a possible aspiration diagnosis) in order that no step in the attack against a malignant growth is omitted.

THE LURE OF MEDICAL HISTORY†

QUACKERY AND NATUROPATHIC LOGIC IN 1795–1825

By HAROLD M. F. BEHNEMAN, M.D.
San Francisco

REMEMBERING that, in the year 1934, the electorate of California were called upon to vote on the Naturopathic initiative (No. 9), it is interesting to review the same unscientific concepts and biased logic which existed one hundred and fifty years ago.

CULTIST SAMUEL THOMSON'S BOOK: THE "NEW GUIDE TO HEALTH; OR, BOTANIC FAMILY PHYSICIAN"

On February 9, 1769, one Samuel Thomson was born, to later become an outstanding cultist in the State of Massachusetts. In the fifty-third year of his life, and in the forty-seventh year of American Independence, he persuaded one Horton Howard of Columbus to publish a volume of one hundred and twenty pages entitled, "New Guide to Health; or, Botanic Family Physician."

By 1827, this book had run through four editions. Like the majority of modern cultist publications, it divided its contents into two main parts—first, the experience and theories of its author, and, secondly, the usual attack upon the medical profession. We learn that the tendency of lay practitioners today to sell, patent or copyright their wares, is at least a century and a half old.

On page 1 of his book, Mr. Thomson reveals his true colors as a cultist in the following utterance, so characteristic of an unscientific mind, devoid of knowledge concerning the fundamental elements of Hippocratic medicine, stating his "Agreement," frequently italicized by himself: "The subscriber, who is the discoverer and proprietor of the system of medical practice contained in this work, agrees to give, whenever applied to, any information, that shall be necessary to give a complete understanding of the obtaining, preparing and using all such vegetables as are made use of in said system, *to all those who purchase the right;* and the purchasers, in consideration of the above information and also what is contained in this book, agree, *in the spirit of mutual interest and honor, not to reveal any part of said information, to any person except those who purchase the right,* to the injury of the proprietor, under the penalty of forfeiting their word and honor, *and all right to use of the medicine.* And every person who purchases the right, is to be considered a member of the Friendly Botanic Society, and entitled to free intercourse with the member for information and friendly assistance."

† A Twenty-five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

To further prevent humanity and science from stealing his thunder, he had John W. Davis, clerk of the Massachusetts District, in 1822, file copyright claims to the title *and contents* of his book.

HOW CULTISTS REPEAT THEMSELVES

In the "Introduction," his defense of his methods, and his opening attack upon doctors of medicine, reveal his inferiority complex. Today, in the chaos of our times, we recognize the tendency of cultists to depend upon one or a few modes of therapy for a wide variety of conditions. All we need do, in proof of this, is to peruse the newspaper advertisements of the quack, the charlatan and the parasites that prey upon honest medicine. It is an old story, for here we find over a century ago Mr. Thomson's statement:

"If, then, a medicine is good in any case, it is because it is agreeable to nature, or this principle of life, the very opposite of disease. *If it is agreeable in one case, it must be absolutely so in all.*" (Italics by this author.)

Does not this resemble a modern advertisement of the colonic irrigationist, et al?

After informing the countryside of the magic healing power of vegetables, he states:

"This greatly disturbed the learned doctors, and some of them undertook to destroy me, by reporting that I used poison: though they made no mention of my using their instruments of death, mercury, opium, ratsbane, nitre and the Lancet."

In combating the forces which seek to menace the public health standards so sanely and patiently



SAM.L THOMSON—*BOTANIST.*

His System and practice originating with himself.

Born Feby 9th 1769.

Fig. 1.—Samuel Thomson.

NEW

GUIDE TO HEALTH;

OR,

Botanic Family Physician.

CONTAINING

A COMPLETE SYSTEM OF PRACTICE

UPON A PLAN ENTIRELY NEW;

WITH A DESCRIPTION OF THE VEGETABLES MADE USE OF, AND DIRECTIONS FOR PREPARING AND ADMINISTERING THEM TO CURE DISEASE.

TO WHICH IS ADDED

A DESCRIPTION OF SEVERAL CASES OF DISEASE ATTENDED BY THE AUTHOR, WITH THE MODE OF TREATMENT AND CURE.

FOURTH EDITION.

BY SAMUEL THOMSON.

Columbus:

PRINTED AND PUBLISHED BY HORTON HOWARD.

1827.

Fig. 2.—Title page of the "New Guide to Health," published in Ohio in 1827.

built up by scientific medicine, we might consider, at least for its immediate effectiveness, the adoption of methods used by the physicians of Massachusetts in 1800! For, as Mr. Thomson states:

"A plan was once laid to take me in the night, but I escaped . . . next, I was bound in irons and thrust into prison, to be kept there through the winter without being allowed bail."

How analogous to the modern cultist's high pressure sales talk is this:

"The practice of the regular physicians, that is, those who get a diploma, at the present time, is not to use those means which would be most likely to cure disease; but to try experiments upon what they have read in books, and to see how much a patient can bear without producing death. After pursuing this plan during their lives, they know just about as much as they did when they began to practice. . . ."

SIMILARITY TO MODERN CULTIST ADVERTISING

In the light of modern cultist advertising, however, the *pièce de resistance* of Mr. Thomson's essay is the final paragraph of his introduction; to wit: "There is . . . one general cause of disease and one general remedy."

If we close our eyes a moment and visualize the present tactics of the cultist, we can, with

District of Massachusetts, to wit:

DISTRICT CLERK'S OFFICE.

BE it remembered, that on the twenty-third day of November, A. D. 1822, in the forty-seventh year of the Independence of the United States of America, Samuel Thomson, of the said District, has deposited in this office the title of a book, the right whereof he claims as author and proprietor, in the words following, to wit:

"New Guide to Health; or, Botanic Family Physician. Containing a complete System of Practice, upon a plan entirely new; with a description of the vegetables made use of, and directions for preparing and administering them to cure disease. To which is added a description of several cases of disease attended by the author, with the mode of treatment and cure. By Samuel Thomson."

In conformity to the act of Congress of the United States, entitled "An act for the encouragement of learning, by securing the copies of Maps, Charts and Books, to the Authors and Proprietors of such copies, during the time therein mentioned;" and also to an act, entitled "An act suplementary to an act, entitled 'An act for the encouragement of learning, by securing the copies of Maps, Charts and Books, to the Authors and Proprietors of such copies, during the times therein mentioned; and extending the benefits thereof to the Arts of Designing, Engraving and Etching Historical and other Prints."

JOHN W. DAVIS, *Clerk of Mass. District.*

Fig. 3.—Photograph of notice of copyright of title of his book, granted by the District of Massachusetts, November 23, 1822.

amazing reality, transplant intact this paragraph, written one hundred and twelve years ago, into 1934; for it smacks of the faddist's sales talk:

"The practice of giving poison as a medicine, which is so common among the medical faculty at the present day, is of the utmost importance to the public; and is a subject that I wish to bring home to the serious consideration of the whole body of the people of this country, and enforce in the strongest manner on their minds the pernicious consequences that have happened, and are daily taking place by reason of giving mercury, arsenic, nitre, opium and other deadly poisons to cure disease."

Later, in this same book, his "New Guide to Health," the author deals a severe blow to our conception of the importance of "bedside manner," personality, etc. Unintentionally, probably, he classifies all physicians into two groups, skillful ones and fools; for he writes: ". . . for poison given to the sick by a person of the greatest skill will have exactly the same effect as it would if given by a fool." What a fitting phrase that would be for the title page of a pharmacology textbook!

Most of us, in the practice of medicine, have heard facetious remarks from patients, such as "It's fashionable to have your tonsils (or appendix) out." It is not new, for in 1822 the botanist wrote: ". . . the doctors have no system . . . almost every great man among them has had a system of his own, which has been followed by their adherents till some other one is brought forward more fashionable."

Mr. Thomson, in a matter of one hundred pages, lists the vegetables, herbs and remedies he considers of value. Their origin, their characteristics and their uses are minutely recorded. The diseases for which they are specific are also named, as well as the manner in which they must be used. Those of us who unfortunately tune in on some so-called medical and health talks over the air soon learn from the nauseating misinformation that the majority of "regular speakers" use numbers for drugs or their combinations, such as "take my powder No. 4 for ulcers, No. 11 for sinus trouble, etc." Alas, even this is not new! Mr. Thomson has all of his drugs, potions, mixtures and remedies numbered. And what is more, he advises for "ague in the face . . . a dose of tea No. 3, a dram of No. 6 . . . then tie a small quantity of No. 2 in a fine piece of cloth, wet with No. 6 . . ." etc., etc.

THOMSON'S CLASSIFICATION OF REMEDIAL AGENTS

Of the maze of diseases and remedies, all of the latter seem to fall into two classes: those which he has found to succeed, and those that have failed. His reasoning is remarkably modern, in relation to the quack and charlatan of 1934; in other words, when a cure was effected the

medicine did it, but when a failure came, he had numerous excuses to give for it. As in the present field of physical medicine which the laity uses extensively without legal or moral curb, some of the modalities are bound to help—the majority of all sick people feel better, at least temporarily, if they have heat, massage, hydrotherapy, rest exercise, etc. And in the minority of cases that fail to improve, the quack has a ready excuse. Here in this eighteenth century volume are two perfect examples of such reasoning.

The first is one of Samuel Thomson's prized remedies. Of it he says: "In fact, there is hardly a complaint, in which this useful medicine cannot be used to advantage." It is listed as "No. 6—Rheumatic Drops." Gaze upon the compound and you will see that enough of this mixture will easily have one so alcoholic that mere pain, as well as other things, will not matter! The treatment is as follows: "One gallon fourth proof brandy, one pound of gum myrrh, one ounce of cayenne pepper. Boil a few minutes or let stand six days." Mr. Thomson states there are two uses for this unfailing remedy: "To remove pain and *prevent mortification.*" (Here, the italics are mine.) In fact, if I am not mistaken, most pathological laboratories are still immersing human tissue in alcohol "to prevent mortification."

And now, to the other extreme, Mr. Thomson's remedy for "cancers of the breast." He writes:

"One of them was as large as a half-peck measure and grew fast to the breast bone. I carried the woman through a course of medicine several times, and applied a poultice of butternut shucks . . . and continued this course for some months, until the bunch had more than half dissolved and had grown off from the bone . . . but she was *taken with a fever in my absence and died.* The other two . . . nature was *too far exhausted* to *complete* a cure." (Again, the italics are mine.)

At times, it appears that Mr. Thomson had some leanings toward faith healing, for he admits the presence of parasites in the body, but refuses to acknowledge the fact of their pathogenicity:

"A great deal is said about worms causing disease. There was never a greater absurdity than . . . the opinion about worms causing disease. The fact is they are created and exist in the stomach and bowels for a useful purpose and are friendly to health . . . they never cause disease, but are caused by it. Those who are in health are never troubled with worms, because they are then quiet and exist in their natural element."

THOMSON'S CONCEPT OF PHYSIOLOGY

The botanist-author was adept at forming strange conclusions to fit his own theories of physiology, to wit:

"When the stomach is diseased . . . the worms try to flee from their danger . . . and they sometimes get into knots and stop the passage to the stomach. Much more might be said on . . . the dangerous practice of giving medicine to kill worms."

Concerning consumption, Mr. Thomson feels that the doctors are grossly in error when "This complaint is called . . . a hectic fever . . . for there is no fever about it . . . the only difficulty is to raise a fever."

Down through the ages have come five metals that scientific medicine still uses for syphilis and anemia. Of these five the ancient cultist has this to say:

"Avoid all minerals used as medicine, such as mercury, arsenic, antimony . . . copper or lead. They are all poison and deadly enemies to health."

One of the author's firm beliefs is:

"The medicine necessary to remove the complaint must be applied to that part where the disease is seated; if in the stomach only, by taking the medicine, it may be removed; but if in the bowels the same compound must be administered by injection . . . as the grand object is to warm the bowels."

THOMSON'S FAMILY MEDICINE CHEST

There was little need of a drug code in the days of Samuel Thomson. If his ideas had been widely accepted, but few drug stores could have existed, for here is his entire stock of medicine for a family for *twelve months:*

"Stock of Medicine for a Family.

1 Oz. emetic herb
2 Oz. cayenne
½ Lb. bayberry root bark
1 Lb. poplar bark
1 Lb. ginger
1 Pint of rheumatic drops

"This stock will be sufficient for a family for one year, and with such articles as they can easily procure themselves when wanted, will enable them to cure any disease, which a family of common size may be afflicted with during that time. The expense will be small, and much better than to employ a doctor and have his extravagant bill to pay."

Even in the dull 1790's all the cultists hid under one cloak, and dragged with them all those irregular practitioners possible to increase their support, as evidenced by the following concerning obstetrics:

"Many men . . . have attended . . . their own wives, and I have never known of an instance of any bad consequences; and if young married men would adopt the same course, it would be much more proper and safe than to trust their wives in the hands of young inexperienced doctors . . their cruel and harsh treatment in many instances would induce the husband to throw them out of the window."

One hundred and fifty years of medical progress have passed since publication of this popular volume, in its fourth edition in 1827 and reissued in 1849, six years after the author's death; and yet despite this progress not only in science, but in civilization, over 110,000 California voters in 1934 signed the Naturopathic initiative petition, contributing to so much additional turmoil in the election campaign of that year. What a pity Samuel Thomson cannot be alive to join forces with some of his modern day successors! His thirty years' experience are not needed here—we have *advanced:* if some of the proposed initiatives become laws, only a general school education of less than full high school standards would be necessary, plus a few enlightening weeks in a cultist school, to enable the botanists of 1934 to practice medicine and surgery in California!

Shades of Hippocrates!

384 Post Street.

CLINICAL NOTES AND CASE REPORTS

SCLEROSING LESIONS OF THE STOMACH, TERMINAL ILEUM AND COLON

REPORT OF CASE RESULTING FROM CHRONIC MERCURIAL POISONING

By ALBERT E. MCEVERS, M.D.
Los Angeles

A FAIRLY extensive search of the literature does not reveal any record up to date of chronic mercurial poisoning that caused gastrointestinal sclerostenosis, with intestinal obstruction.

REPORT OF CASE

Mrs. E. B., age 68, admitted to hospital March 4, 1931. Family history irrelevant.

Past History.—The patient was desperately ill when she entered the hospital and it was difficult to get her medical history. She had been fairly well until three years previous to the present illness, when she had an alleged nervous breakdown, confining her to bed for some time. From then on, constipation gradually increased, which required large doses of cathartics and enemas for elimination. She had many attacks of vomiting, with indefinite generalized abdominal pain and abdominal distention, which became more persistent and frequent.

The patient lived alone, and the only additional information obtained from relatives was that she had taken patent blood medicine for many years. Whether this blood medicine contained mercury could not be definitely established.

Course of Terminal Illness.—Three days prior to her admission to the hospital the patient had an attack similar to previous ones, but was unable to relieve herself. She had persistent fecal vomiting, generalized abdominal pain, and distention.

Examination.—A poorly nourished, white female, desperately ill, perspiring profusely, dehydrated and toxic, with a distended abdomen; temperature, 101 F., pulse 120, respiration 28. There was no visible peristalsis, no tinkling. She represented an end-stage of obstruction. There were no scars from former operations, no hernia; rectal examination revealed little, if any, information.

Hemoglobin (Dare) 85 per cent; leukocyte count, 33,900; erythrocyte count, 4,750,000. Urine was cloudy, specific gravity 1015, acid reaction, trace of albumin, no sugar or acetone. Microscopic examination showed a few granular casts, a few leukocytes, no erythrocytes.

Treatment.—Intravenous infusions and hypodermoclysis were given to replace fluid and chemical loss. The patient was too ill to undergo extensive surgery. Under local anesthesia, an enterostomy, without exploration, was done. There was considerable drainage from the enterostomy tube; however, no improvement was noted, and the patient expired in twenty-four hours.

Postmortem.—The interesting findings at autopsy were sclerosing lesions of the stomach, terminal ileum, lower end of descending colon and sigmoid.

The stomach was leather-bottle type. For three feet proximal to the ileocecal valve, the terminal ileum was small, about one-half inch in diameter, cord-like, and indurated. At the proximal end of this sclerosed portion of the ileum, there was complete obstruction; above the obstruction the bowel was thin, walls were stretched and ballooned out. The lumen at the distal end of the sclerosed lesion would admit the tip of a small probe. The lower part of the descending colon and sigmoid presented a similar appearance, being a little larger than the terminal ileum, as was its lumen. The rectum appeared more or less normal.

The gross appearance of these lesions suggested Krompecher's carcinoma disseminatum or "linitis plastica." Specimens of the tissue were examined by Dr. George H. Hansmann, who reported as follows:

"The specimen identified as G-31-79 is composed of sections from the stomach (pyloric end), terminal ileum and descending colon.

"Two sections of stomach are present, both taken in the region of the pylorus. One section shows an absence of mucosa with the base of the ulceration made up of chronic granulation tissue. This ulcer gradually merges into another, whose underlying structures are composed of normal stomach wall which is infiltrated with polymorphonuclears. This denuded area is covered by fibrin and polymorphonuclears. There is no evidence of neoplasm. Several large vessels in the old ulcer area show marked subintimal proliferation with a resultant very small vessel lumen.

"Section of the ileum, taken from the upper and middle segments of the terminal three feet submitted, show nothing remarkable. A section, however, taken near the ileocecal valve shows necrotic débris in the lumen, which is heavily infiltrated with polymorphonuclears. Organisms are present in this débris. The wall has a few polymorphonuclears in it.

"The section of the descending colon shows a markedly contracted colon, so that only a very small lumen remains. The mucosa is almost completely absent, being replaced by necrotic tissue and fibrin. The submucosa is quite edematous, but also shows some increased amount of connective tissue. The most striking picture, however, is the injury to the vessels in the submucosa. The arteries appear to be more involved than the veins. They show fibrinous thrombi in their lumina in variable amounts, from complete occlusion to only a small deposit on the intima. The whole wall is heavily infiltrated with polymorphonuclears.

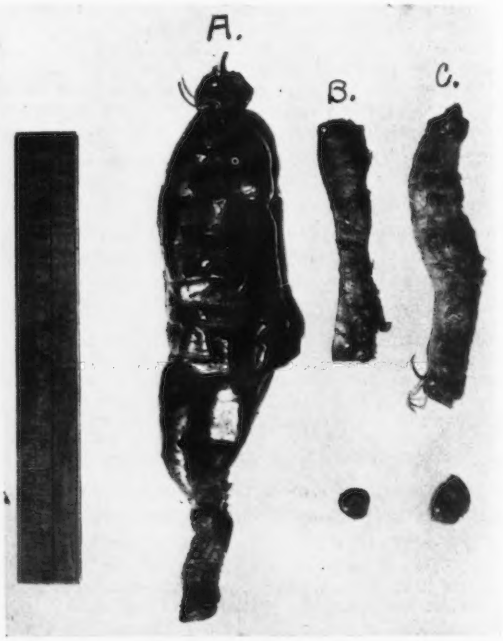


Fig. 1.—Terminal ileum and sigmoid: (*a*) showing the point where obstruction became complete in the terminal ileum, the ballooned and thinned-out segment of the ileum above the obstruction, and the cord-like, sclerosed and thickened bowel below; (*b*) terminal ileum with cross section showing almost complete loss of lumen; (*c*) section of the sigmoid with cross section showing the lumen, which is larger than that of the terminal ileum, but fairly well obliterated.

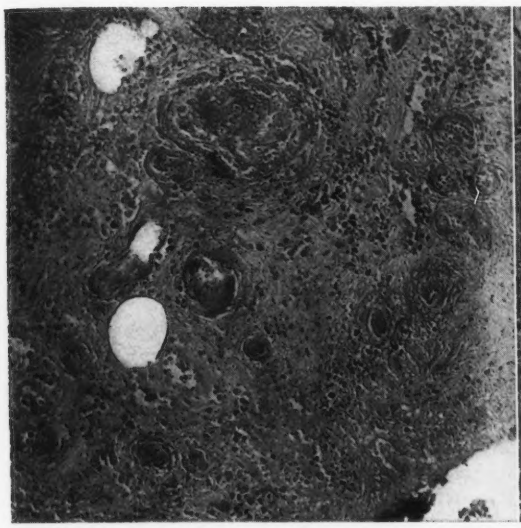


Fig. 2.—Mercurial poisoning: tissue from lesion of stomach in this case; note number of occluded vessels, ulceration and inflammation.

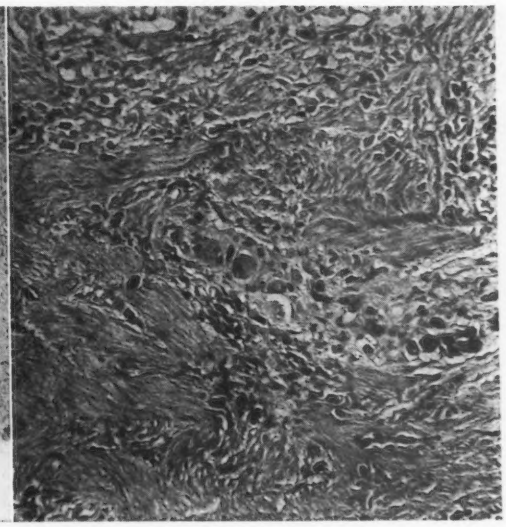


Fig. 3.—Linitis plastica: Krompecher's carcinoma disseminatum; note small epithelial infiltration and scar.

"In the above description it is quite evident that there is no evidence of neoplasm. It also appears that the lesion is one of a vascular nature. The extensive necrosis in the lower ileum and colon appears to be secondary to the vascular occlusions which are easily demonstrable. The etiologic agent producing this vascular injury remains obscure. The sections were examined by Dr. S. B. Wollbach of the Harvard Medical School, and his conclusions are no more definite than ours.

"There is yet, however, one thing which may be done in an effort to find an etiologic agent. This is the examination of the tissue for the presence of mercury."

Tissue from these specimens was forwarded to the Pharmacological Laboratory of Western Reserve University, and a chemical analysis of sections of the organs for the detection or presence of mercury gave the following results:

Organ	Weight	Mercury
Colon (cecum)	42 gm.	9.9 mg. hg.
Stomach	45 gm.	0.2 mg. hg.
Ileum	230 gm.	2.0 mg. hg.

COMMENT

In view of the report of the chemical analysis made from sections of the colon, stomach, and ileum, it would seem that there is established a definite relationship between these lesions and the mercury revealed.

The method of analysis used does not indicate in which form the mercury existed, and the mercury present was recovered as metallic mercury. Normally, if no mercury has been administered or ingested the tissues do not contain detectable amounts.

It has been found that after mercury medication a portion of the injected mercury is retained indefinitely in the body; 50 to 60 milligrams with therapeutic courses of intramuscular or intravenous injections of soluble inorganic or organic compounds, and from 200 to 700 milligrams of mercury are retained in the body following intravenous injections of colloidal solutions.

Mercury is eliminated by the bowels, kidneys, liver, and saliva. The main outlet of mercurial compounds is through the kidneys. The mercury compounds of small solubility pass out of the system mainly through the intestine in the form of mercuric sulphid.

Myers and Throne [1] call attention to the possibility of heavy metals entering one's system through water, food supplies and occupational sources. Lead drinking pipes are frequently a source of contaminated water according to them, and insecticides sprayed on raw fruits and vegetables are another.

It would be interesting to have a chemical analysis made for the presence of mercury on similar tissue in patients where there is a history of having taken mercury in various forms therapeutically; also on tissue from patients who have a clear history of no mercury ingestion.

DIAGNOSIS

Krompecher calls attention to a group of benign cases of linitis plastica, which he termed "gastro-intestinal sclerostenosis." Leith, as quoted by Ewing, described a case of this type as noncancerous cirrhosis. The lesion involved stomach, ileum, and colon, but the microscopical report is somewhat lacking in details, although the author positively excludes carcinoma.

It is apparent from the literature that there are cases of linitis plastica that are not malignant. Boyd describes fibromatosis of the colon affecting any part of the large intestine, but more frequently in the pelvic colon, and the rectum. The bowel wall is thickened, due to the formation of dense inflammatory tissue in the submucous coat. The mucosa is nodular or polypoid, as in tuberculosis, and may be ulcerated.

Boyd further states that the exact cause of this condition is not known, but evidently is chronic inflammatory in nature. The infection probably

gains access to the submucosa through the mucous membrane by some abrasion or other local lesion.

G. Faroy [2] reports three cases of plastic linitis, and he discusses the rôle of syphilis in the pathogenesis of this disease. He indicates that syphilis frequently is the cause of cirrhosis, and that it even plays a rôle in cirrhosis due to alcoholism or other intoxications; and that syphilis alone is able to injure the arterial coats separately and en bloc, as well as sclerosis in almost every other organ.

There is a difference in the gross specimen in this case and that of the so-called linitis plastica. The trained pathologist brings out these differences by touch, which indicates to him differences in elasticity and friability of the tissue. The photomicrographs (Figs. 2 and 3) are shown for direct comparison. It is immediately apparent that the gross appearance is vastly different between the photomicrograph of this case and the one of linitis plastica type of carcinoma of stomach.

SUMMARY

The demonstration of metallic mercury recovered in appreciable amounts from the tissue taken from the lesions in the stomach, terminal ileum, and colon, establishes a relationship with the gastro-intestinal sclerostenosis. I believe that mercury was the etiologic agent responsible for the vascular lesions found histologically.

1930 Wilshire Boulevard.

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1. Myers, C. N., and Throne, Binford: The Relationship of Arsenic to Public Health, New York State Journal of Medicine (July 15), 1929.

2. Faroy, G.: Three Cases of Plastic Linitis—The Rôle of Syphilis in the Pathogenesis of This Disease, Archives des maladies de l'appareil digestive et de la nutrition, 14:616-634 (July), 1934.

A SIMPLE SPLINT FOR FORCED EXTENSION OF THE ELBOW*

By Gordon M. Morrison, M.D.
San Mateo

THE improved plaster now available makes possible the fabrication of many useful orthopedic devices, using the molded plaster instead of metal parts. The splint described is a modification of the diamond splint, and is useful for producing extension of joints fixed in flexion, as in stiffness of the elbow, following the healing of a fracture in flexion. This device was designed for such a case after prolonged attempts with physiotherapy gave poor results. Twenty-four hours after application, this stiff elbow joint, which was refractory to other types of treatment, was in complete extension. Construction of the appliance is self-explanatory from the illustrations.

TECHNIQUE

A circular plaster is applied over stockinette in two segments, one above and one below the affected joint. A one and one-half inch barn-door hinge is placed at the flexion angle and fixed in place with additional plaster. Two small, right-angle brackets are then incorporated near the distal ends of the plaster. The joint is next put through any possible movement to correctly align the hinge and brackets before the plaster is completely set. When the plaster is sufficiently dry, it is bivalved; the drilled tongue depressors are bolted into place, and a few elastic bands are placed, as shown in the diagram, and the apparatus is reapplied to the affected extremity, with bandage or adhesive.

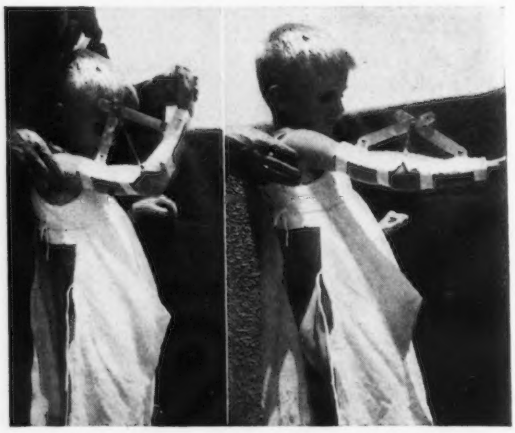


Fig. 1 Fig. 2

Fig. 1.—Splint applied to flexed elbow. Rubber bands under tension.

Fig. 2.—Elbow joint in extension. Rubber bands relaxed.

San Mateo Community Hospital.

* From the Orthopedic Service of E. W. Cleary, M. D., Community Hospital of San Mateo County.

BILATERAL SALIVARY CALCULI

By H. P. Merrill, M.D.
Los Angeles

WHILE calculi in the salivary glands and ducts are fairly common, and there is no reason why they should not occur bilaterally, I can find no reference in the literature to such an occurrence. Two or more stones in the same gland or duct are mentioned, but one in each submaxillary duct is rather unique.

REPORT OF CASE

Case 1.—This patient, a man of thirty-seven, had gone through several attacks of pain and swelling along the left side of the jaw and under the tongue. These had been diagnosed as quinsy, and had subsided without much trouble or treatment. This time the pain and swelling were worse, and there had been some fever for three days.

The local physical signs were typical of a blocked submaxillary duct, with cellulitis of the floor of the mouth. There was some swelling externally. An incision along the floor released considerable pus and saliva. A hard mass was felt in the cavity at this time. The symptoms subsided rapidly, and three days later the calculus presented in the wound and was removed.

Before this wound had healed, the patient returned with pain and some swelling on the right side. A probe passed into the submaxillary duct touched a hard mass in about the same position as the one on the left. This calculus was also removed intraorally under local anesthesia.

Both calculi were oval and about 1.5 centimeters long by 0.75 centimeter in diameter. They were very hard, as compared with most salivary calculi.

458 South Spring Street.

BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

DYSMENORRHEA

ETIOLOGY AND PATHOLOGY

LYLE G. MCNEILE, M. D. (523 West Sixth Street, Los Angeles).—Unfortunately, the exact etiology of dysmenorrhea is still unsettled. Pathologic changes are not at all constant, and it is certain that no characteristic changes exist which would apply to all cases of dysmenorrhea.

As Curtis states, "Like eclampsia, dysmenorrhea is a disease of theories, and no single conception fits all cases. Many ideas, once implicitly accepted, have had to be discarded in the light of further knowledge." Most authors divide dysmenorrhea into two types, primary and secondary. The secondary type is caused by pathologic conditions in the pelvis, usually uterine fibroids, endometriosis, salpingitis, ovarian cysts, or chronic inflammatory disease. Since the etiology of the secondary type is known, surgical correction of the pathologic disturbance usually cures the menstrual pains.

Primary dysmenorrhea, on the other hand, is not associated with any abnormality in the pelvis, and there is no unity of opinion concerning the exact cause of this type of pain. The most current theory has been advanced by Novak and Reynolds, who are of the opinion that the immediate cause of dysmenorrhea is an exaggerated contractility of the uterus, manifested by pain, if the pain threshold is lowered, or if there is an actual unbalance between the two hormones that appear to regulate this. These two hormones are the follicular factor, the normal stimulant of uterine excitability, and progestin, the normal inhibitor. Other investigators believe that the pains associated with menstruation are due to an unbalance in the pelvic sympathetic system. It seems to the author probable that both factors are involved.

In his opinion, the rôle of malpositions of the uterus in producing dysmenorrhea has been greatly exaggerated. While it is true that both anteflexion and retroversion of the uterus are frequently associated with dysmenorrhea, the physician who assumes that the correction of these conditions will likely cure the dysmenorrhea is usually doomed to disappointment.

* * *

SYMPTOMS AND PROGNOSIS

ALBERT V. PETTIT, M. D. (2000 Van Ness Avenue, San Francisco). — I find difficulty in profitably discussing this part of the symposium assigned to me without making occasional excursions into the field of etiology and therapeutics.

Let us first consider the symptoms of primary or essential dysmenorrhea, that is, that group not dependent on gross pelvic pathology even though it may at times be associated with it.

The symptoms of primary dysmenorrhea do not begin with the menarche, as is generally believed, but from one to ten years after the regular establishment of the menstrual flow. The symptoms begin as mild discomforts, gradually increasing in intensity until the menses are often completely incapacitating.

A typical attack begins shortly before the appearance of the flow, often as much as two days before. Usually the first symptom is pain, either cramp-like or steady, felt in the region of the uterus. This is often preceded by sacral backache and practically always accompanied by it. Headache occasionally with nausea and vomiting, sweating with cold skin and pallor quickly follow. These symptoms tend to increase until the flow is well established, when they suddenly subside. The suddenness with which the symptoms sometimes occur and later disappear is suggestive of allergic phenomena, but the sympatheticatonia may be entirely due to uterine pain, and the striking cure of these symptoms by presacral sympathectomy is very suggestive of this.

In certain cases all of the above symptoms are present, in others only a few; but it is surprising how often a careful history will reveal an alternation in the severity of the symptoms, a painful menstruation alternating with a relatively comfortable one. The one symptom most bitterly complained about is the backache from which the patient feels there is no escape.

In dysmenorrhea of the secondary type, that is, those in which gross pelvic pathology is responsible for pain, in the group made up of those having congenital stenoses or atresias, the lower abdominal pain begins with the menarche, and becomes very violent after two or three periods; so that menstruation in patients with complete obstructions show violent uterine pain with nausea, vomiting, shock, tender and often rigid abdomens, occasionally fever and later a palpable mass. In these cases there is pain with each menstruation, and all symptoms become progressively worse.

Secondary dysmenorrhea, due to endometriosis or adenomyoma, may appear at any time after the menarche, but usually after several years, often late in life. The symptoms cannot be distinguished from that of primary dysmenorrhea, showing essentially the same vagaries, but may begin several days before the onset of the flow; may be accompanied by a discharge of blood from the rectum, and may show marked evidence of peritoneal irritability. Palpable pelvic masses, without cervical infection with the above symptoms, make the diagnosis relatively simple.

Pain, which simply accompanies menstruation due to inflammation or with fibrosis and adhesions following inflammations, is generally adnexal in location and should be called menorrhalgia. In this

group there is no characteristic time of appearance of the symptoms. In my experience, inflammations play an insignificant rôle in the production of menstrual pain.

It is impossible to give a prognosis which will cover all classes of dysmenorrhea.

Generally speaking, uncomplicated primary dysmenorrhea tends to disappear after the age of thirty, usually disappears after a pregnancy, and many persons are free from pain after regular intercourse is resumed. Unfortunately, many of these patients are very infertile. The cure in those who become pregnant is not necessarily due to the pregnancy itself, but to a correction of the endocrine imbalance, which also caused the sterility. Results of treatment in primary dysmenorrhea have improved markedly during the past few years, and one has only to mention the use of atropin, thyroid extract, emmenin, irradiation of the hypophysis, alcohol injection of the posterior uterine sympathetic nerve supply, and presacral sympathectomy, to indicate what may be done with good prospects of improvement and cure of the painful sensations arising in the uterus. Psycogenic components in varying degrees are present in practically all cases of dysmenorrhea due to the inevitability of recurrence. These components disappear rapidly after any real relief.

Treatment of congenital or acquired anomalies in the pathway for escape of menstrual discharges is surgical. Treatment of adenomyomata and endometriomata is effective by surgery, which is destructive, or by irradiation, which may or may not be destructive. In any event, the treatment of the pain has an excellent prognosis, but the child-bearing function is lost.

Treatment of menorrhalgias due to inflammatory disease is mainly hyperthermia, with or without surgery, which can be conservative. The prognosis is good in such cases.

An interesting suggestion as to the etiology of menstrual backache has been recently made by Dr. E. Chamberlain of Temple University, who thinks that it is probably due to a cyclic recurring sacro-iliac subluxation somewhat similar to the change in the pelvic articulations seen in pregnancy. Treatment of this menstrual backache as an orthopedic problem just as most, if not all other backaches in the female should be treated, may allow us to give a good prognosis in regard to this part of dysmenorrheal symptomatology also.

* * *

DIAGNOSIS AND TREATMENT

L. A. Emge, M.D. (Stanford University School of Medicine, San Francisco). — Dysmenorrhea (menorrhalgia), like headache, is only a symptom and not a pathologic entity nor a disease in the true sense of the word. Strictly speaking, the patient makes the diagnosis of dysmenorrhea, but the physician searches for the cause. This is a complex problem and demands painstaking attention to a number of details, without which treatment is haphazard and disappointing. It is self-evident that a good history is essential. Physical examination must be complete. Laboratory studies should include at least a complete blood count and, if possible, a B. M. R. determination. In my own work, I make it a point to obtain data which enable me to answer the following important questions:

1. When did pain occur first in relation to the menarche?

2. When does pain occur in relation to the individual menstrual cycle?

3. What is the type, location, and duration of pain, and what are the endocrine stigmata of the body; and are there reflex disturbances?

4. What is the type of uterus (shape, size, position)?

5. How does the physical make-up of the patient compare with diet, exercise, work, and body hygiene?

6. What is the relation of the functional or emotional constitution of the patient to the severity of the pain complained of (evaluation of pain)?

7. Does pelvic pathology exist; and if so, is it incidental to, or has it a bearing upon dysmenorrhea?

With these questions satisfactorily answered, one can readily determine whether dysmenorrhea is congenital or acquired. This is of importance because the former is frequently of endocrine origin, while the latter is more often of organic origin. So-called psychogenic types of dysmenorrhea may fit into either category and are the most difficult to diagnose.

Most of the functional or endocrine types of dysmenorrhea occur simultaneously with the onset of menstruation and usually last not more than twenty-four hours. Comparatively few women experience pain over longer periods. Such pain is usually severely spastic in type, and often accompanied by nausea and vomiting, with general prostration. This combination of pain and reflex disturbances is less often encountered in secondary or acquired dysmenorrheas. In the latter type, pain more frequently appears before menstruation, beginning as early as seven to ten days prior to the beginning of the flow. This may be indicative of pelvic inflammatory disease involving the ovaries, endometritis, endometriosis, adenomyosis, large submucous polyps, or pedunculated fibroids. Ovarian cysts rarely are accompanied by dysmenorrhea, and then only when secondary inflammatory changes are present in the pelvis. Likewise, uterine displacements, as such, rarely give rise to dysmenorrhea. Many developmental and positional anomalies are only part of a general developmental disturbance due to endocrine deficiencies, the latter being the real factor in pain production. This is most often the cause of primary or functional dysmenorrhea. One cannot stress this point too forcefully, for it is a patient of this type who so frequently is subjected to uterine suspension without relief from pain. At times dysmenorrhea accompanies acquired uterine displacements, and in my opinion is due to the formation of pelvic varicosities. Patients suspected of such a condition should be examined in a standing position. Only then can the enlarged

veins be readily palpated. The insertion of a well-fitting pessary after replacement of the fundus is the best means to evaluate the importance of uterine displacements, so far as pain production is concerned. The type of pain which accompanies retroversion is very distinct for the two general types of dysmenorrhea. In the functional or endocrine group, pain is usually of the typically spastic type accompanied by reflex disturbances, while in the acquired group it is usually a disseminated pain radiating laterally along the posterior aspects of the thighs.

Next in importance in the diagnosis of dysmenorrheas is the evaluation of pain. This is a difficult task, requiring a keen appreciation and thorough understanding of the psychic make-up of women. Degrees of pain are undoubtedly differently interpreted by different individuals. This holds good for both patient and physician. Unless one delves into the functional behavior of the individual, one cannot be sure how much of the pain complained of is real, and how much of it is an expression of a defensive mechanism or some other form of a disturbed psychologic balance or emotional instability. I do not share the belief that all types of functional dysmenorrhea are purely psychogenic in origin, but I am convinced that numerous individuals magnify pain because of emotional instability. Later, when discussing treatment with such patients, this point must be stressed with tact and in a sympathetic vein, so that the patient may appreciate that her own efforts to forget her infirmity are a step toward a more speedy relief.

In the physical examination a careful observation of body stigmata will often give the clue to an endocrine disturbance. Blood and metabolism studies are indispensable for a careful diagnosis. Minor degrees of hypothyroidism are very common, and often the sole cause for dysmenorrhea. It is well known that anemic and chlorotic girls frequently suffer from dysmenorrhea. If properly diagnosed, these conditions are easily corrected. In the pelvic examination the size, shape, and position of the uterus should be carefully noted. The hypoplastic uterus frequently indicates hypopituitary disturbances. The infantile uterus is most often indicative of hypo-ovarianism, and the tall, bulky uterus which has not lost its infantile proportions is most frequently associated with hypothyroidism. Pelvic search for tumors, and fixations due to pelvic inflammatory disturbances, and endometriosis are next in importance. I should like to call attention to the fact that dysmenorrhea accompanying the latter condition invariably appears years after the onset of menstruation, and is characterized by the progressive severity of pain and by the appearance of pain late in the menstrual period, lasting for some days after the cessation of the flow. These patients also frequently complain of premenstrual soreness well distributed throughout the pelvis.

To recapitulate, the diagnosis of dysmenorrhea concerns itself with determining (1) the type of dysmenorrhea; (2) its relation to the menstrual cycle; (3) the evaluation of pain; (4) its localization; (5) the evaluation of the organic make-up; and (6) the evaluation of pelvic findings.

Unless one can make a careful diagnosis, the treatment of dysmenorrhea is about as unscientific as that of headache. I do not wish to imply that it is always possible to devise the proper type of treatment for every patient even after a very careful analysis of the complaint, but one can come close to such a goal.

Since there is a large group of young women who, under the stress of school, college, or business life, neglect their body hygiene, one should delve into their mode of living as well as their mental fitness, and give proper advice as to exercise and rest and mental hygiene. Sex questions must be cautiously and tactfully approached. In these days of diet fads many young women suffer from food deficiencies. Anemias should be corrected and a proper dietary regimen should be ordered regardless of the wishes of the patient to remain slim and boy-like. It has been advocated recently that a high carbohydrate diet, because of its influence on blood sugar, relieves dysmenorrhea, for it has been found that in certain individuals hypoglycemia and dysmenorrhea go together. As a rule, there is no reason why the average young woman should curtail her activities during menstruation, for there is no proof that moderate athletics have a detrimental influence on menstruation. Moderately hot baths or showers create no disturbances when used during the menstrual flow. In fact, in many instances minor types of dysmenorrhea are completely relieved if patients are permitted to continue their ordinary activities and make use of hot baths freely during the menstrual period. I have not hesitated to let young women take hot douches during menstruation in order to relieve pain, and I have never found that this procedure has created pelvic disturbances. To the contrary, heat applied in this manner, or in the form of a "sitz" bath, is good medicine, and is quite preferable to more radical procedures. In this connection, it may be of interest that in both primary and secondary types of dysmenorrhea the utilization of detergent suppositories is of a distinct benefit to the patient. For many years I have used such a suppository commercialized by Wyeth and marketed as No. 426, which, aside from the detergent agents, contains an anodyne. I order the patients to precede the use of these suppositories with a copious plain hot water douche, to be taken night and morning, beginning three days before menstruation and carried into the second day of the flow. This procedure has given immediate and often permanent relief after a few months of self-treatment. The patient soon learns how often and how long to use these agents. It saves her office visits and medical care, and often relieves her sufficiently from pain to continue her daily duties during menstruation with reasonable comfort. It is my experience that in obscure types of functional dysmenorrhea where endocrine therapy has failed, this simple procedure will give satisfactory relief.

Where dysmenorrhea is frankly due to an endocrine dyscrasia the choice of treatment may be

very simple or very complicated. The simplest problem offers itself in thyroid deficiencies. It is rather interesting to know in this connection that in hypothyroidism dysmenorrhea is about as often relieved by the administration of thyroid as by iodin therapy. Individuals who present the picture of pituitary deficiency are frequently relieved by the administration of anterior pituitary-like hormones, of which there is a wide range of choice—antuitrin—S, follutein, Collip's A. P. L., and similar substances. The dosage is arbitrary, and is to be determined by the amount of relief experienced. Usually one to two cubic centimeters given hypodermically every other day for six doses preceding menstruation, will produce the desired result. The disadvantage of this treatment is the necessity of the patient's visits to the doctor's office. Therefore, whenever possible, one should try ether-washed emmenin, a placental hormone of the anterior pituitary-like type. This is taken by mouth in dosages varying from one to three teaspoonfuls daily. In my own experience it is about as efficacious as hypodermic medication, but not always well tolerated because of the harsh taste. It is best to start with a fairly liberal dose, reducing the amount after relief from pain has been experienced. It is not at all unusual to obtain permanent relief after two or three months of such a regimen.

Individuals of the hypo-ovarian type are often relieved by the administration of estrogenic substances such as theelin, amniotin, folliculin, folliculin menformon, progynon, and hypodermic agomensin, and other similar substances. Here, too, the dosage is arbitrary. The trend is toward larger doses up to 1,000 international units, given hypodermically every other day until relief from pain has been obtained. After this the interval is increased, and ultimately the dosage is reduced. Many of these substances are put up in oil and are not always well tolerated by every patient. The advantage claimed for the oil preparations is that they are absorbed more slowly, which permits longer intervals between injections. I am not certain that this is correct. The administration of the water-soluble types, such as folliculin menformon, is painless, but is said to require a longer continuation of administration at shorter intervals. I also doubt this statement. One must take into consideration the reaction of the patient in choosing the proper agent and the proper dosage.

The disturbing factor in treating dysmenorrhea related to endocrine disturbances is that, scientifically speaking, it is not always rational. One can understand that the anterior pituitary-like hormones such as emmenin, antuitrin-S, follutin, A. P. L., etc., will relieve a spastic uterus, because they also produce an increase in uterine and para-uterine vascularity. It is not so easy to rationalize the use of thyroid and iodin, and it certainly is not easy to explain the action of estrogenic substances, for they are supposed to produce a contraction of the uterus. Nevertheless, clinical experience and results justify the use of these substances, and at times demand an interchange or even a combination of substances. After all, it is the relief of the patient that counts, even if our efforts cannot be explained on a purely scientific basis; and in its final analysis it matters not whether the action of the substance is specific, pharmacodynamic, or psychotherapeutic. All of these factors are cleared up by time and usage. At this particular time our knowledge of the endocrine behaviors and their relation to our functional lives and our sympathetic nervous systems is still very obscure. Laboratory experimentation alone is not going to give us an answer as to how these substances work in the human being. We have to go on trying, and thus add to our store of knowledge by trial and error. The boost that has been given the poor sufferer from dysmenorrhea by the endocrine substances is the greatest advancement made in therapeutics in the field of gynecology.

The question of treatment of acquired dysmenorrhea due to inflammatory or neoplastic disturbances can be answered with few words. In the first place, comparatively few inflammatory disturbances are accompanied by dysmenorrhea, once they reach the chronic stage. An exception to this is endometriosis, and that rare disease endometritis! If the ordinary local treatments such as I have outlined bring no success, the various forms of intensified heat treatment are worth trying. Diathermy has not been successful in our hands. We have had no experience with the Elliott machine, but we have had extensive experience with hyperthermia given in the form of high-heat prolonged baths. The use of this method is rather new, and we can only give our impressions. I prefer to simply state that there is a field for this method. From other sources I have learned that hyperthermia induced by short-wave electric currents promises similar results. If any of these conservative forms of treatment fail to produce results, surgical methods are in order. The same holds true of dysmenorrhea due to benign neoplastic disturbances. Here surgery is usually preferable to irradiation, since the ovaries can be preserved.

I have left the discussion of surgical and mechanical therapy of functional dysmenorrhea to the last. At times when all other therapeutic measures have failed, we are forced to resort to mechanical treatment. It should be resorted to only after all simple methods have been exhausted. So-called intractable dysmenorrhea is very rare. Just what constitutes intractability depends in a large measure upon the state of mind of both patient and doctor. And may it be said without malice that the more patient the doctor the less the incidence of intractability—and clever hands are often the reason for a surgical approach to the problem, when a patient mind would have found an easier and often better way out.

The simplest form of mechanical treatment is the use of negative galvanism applied directly to the cervical canal. It can be used either in the form of a smooth or interrupted current, and must be given over a period of several months. The use of negative galvanism, which produces cervical dilation and increases the uterine blood supply, is in most instances preferable, and more perma-

nent than forceful cervical dilation under an anesthetic. It is decidedly preferable to the stem pessary. It must not be used in the presence of cervicitis.

A very efficacious method of controlling dysmenorrhea, which has failed to respond to other measures, is the alcohol block of the paracervical ganglia, originally advocated by Blos. This method demands a keen sense of touch, and vivid visual memory of the relations of the structures in the immediate vicinity of the cervix. By passing a 20-gauge 3-inch needle through the posterior lip of the cervix into the paracervical tissue in the vicinity of the angle formed by the uterosacral and broad ligaments, five cubic centimeters of 5 per cent novocain in 70 per cent alcohol are injected slowly into the areolar tissue which contains Frankenhäuser's ganglia. One injection is usually sufficient, and gives relief to about 80 per cent of patients. A repeated injection relieves another 10 per cent. For those who are not relieved, we advise resection of the presacral nerve. Surgery of the displaced uterus is rarely necessary, and will give relief only if pain is due to unusual venous dilatation, varicosities and varicoceles of the pelvic circulation. No uterus should be suspended for dysmenorrhea without first having convinced one's self that replacement of the organ by a well-fitting pessary relieves the pain. Should the operation be indicated, the basal ligaments should be shortened and unusually large varicosities ligated.

When dysmenorrhea is known to be of inflammatory, neoplastic, or endometrial origin, destructive surgery is unavoidable.

Radiologic treatment of either the pituitary or ovarian regions is of very doubtful value and demands a critical interpretation. Doctors Newell and Pettit of this institution have recorded their studies, and they will appear in this JOURNAL in due season.

There then remains nothing further to say except that many women who suffer at the time of their menstrual periods are relieved spontaneously after they enter their "twenties." Childbirth and orderly sex life bring relief to untold thousands of others, while some go on suffering for the entire span of their menstrual life, learning to bear their burden just because they are women.

Psychic Behavior at High Altitudes.—Jongbloed investigated whether the oxygen deficiency would impair the alertness of an aviator flying at an altitude of 5,000 meters, pointing out that such heights occasionally are necessary when high mountains have to be crossed, particularly if cloudiness obscures the mountains. The alertness of the aviator is especially important in case of so-called blind flying that may be necessary on account of the cloudiness. The author found that the rarefaction of the atmosphere at the altitude of 5,000 meters causes only slight impairment of the mental alertness in the radio telegrapher. He found that the slowing down of the mental alertness was most noticeable in the choice reactions, the regularity being influenced more strongly than the duration of the reaction time. However, the author is convinced that a trained aviator can safely fly for about an hour at an altitude of 5,000 meters, but that a further increase in the altitude decreases the alertness rapidly and, for instance, blind flying during bad weather makes higher demands on the alertness of the aviator. Three of the author's test subjects had to breathe oxygen shortly after an altitude of 5,000 meters had been reached, while four others had difficulties. This indicates that at this altitude difficulties may be encountered in passengers, for, although the aviators can be selected in air transportation, the passengers cannot. Accordingly it is necessary to take measures so that air transportation will not cause difficulties even in the weakest of the passengers. The author states that an oxygen supply should be available for altitudes of more than 5,000 meters. However, he thinks that breathing-masks and other instruments are likely to alarm the passengers and should be avoided. He thinks that since the cabin of a modern plane has a regulable ventilation system, it would probably be possible to keep the oxygen tension high enough by forcing in a supply of oxygen.—*Klinische Wochenschrift.*

Age Incidence of Causes of Illness.—Collins presents the results of periodic canvasses of 8,758 white families living in 130 localities in eighteen states and including 39,185 individuals. Each family was visited at intervals of from two to four months for a period long enough to obtain a sickness record for one year. On the first call a record was made of the number of members of the household, together with data about sex, age, marital status, and communicable disease history of each person. On succeeding visits the canvasser recorded all illness that had occurred since the preceding call, with such pertinent facts about each case as the date of onset, the duration of disability and of confinement to bed, the nature of such medical service as was obtained, and the termination of the illness. The surveyed families include representation from nearly all geographic sections, from rural, urban and metropolitan areas and from all income classes, and consist of both native-born and foreign-born persons. The proportions of these various elements included are not identical with those in the population of the United States, but the variations are not generally large. In other respects also the surveyed group is not dissimilar to families in the general white population of the United States. The age incidence of all the specific diseases that were reported in sufficient numbers to approximate a reasonably accurate age curve are depicted in graphs and tables. While there are irregular chance variations in many of the curves, they serve to indicate the general picture of the age incidence of even the less frequent diagnoses.—*Public Health Reports.*

If one continues to ply one's mind, growth ensues, even in the years formerly supposed to be marked by stagnation and decay. To foster this growth one must not trust too much to the casual gains of everyday work and experience. One must put forth well-directed efforts. Merely to maintain one's status is not enough. He who is satisfied to stand still will soon slip backward. To grow one must go on learning. So it has come about that education, formerly thought to be an activity limited to the days of one's youth, is now seen in one form or another to be desirable in all periods of life. Thus one continues to improve; thus one keeps young.—Leon J. Richardson.

"Poor posture" is a sign that the child needs a careful and complete medical examination to discover the underlying cause of poor posture. The "poor posture," like toothache, is really nature's warning that something is wrong and the child needs the physician's help to discover what that "something" is and to tell him how to correct it. When the cause is removed or corrected, the poor posture usually disappears. Treat the child, not the posture.

Some of the grotesque attitudes in which children sit or lie have a real purpose back of them, for they relax the child's tired muscles and let him "rest up" most quickly.—LeRoy A. Wilkes, M. D.

The ladder of life is full of splinters, but they always prick the hardest when we are sliding down.—W. L. Brownell.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

CALIFORNIA MEDICAL ASSOCIATION

ROBERT A. PEERS.....President
EDWARD M. PALLETTE.....President-Elect
FREDERICK C. WARNSHUIS.....
Secretary-Treasurer and Associate Editor for California

STATE AND COUNTY SOCIETY ACTIVITIES

WHAT DID YOU SAY?

If you are tempted to reveal
A tale someone to you has told
About another, make it pass,
Before you speak, three gates of gold,
Three narrow gates—first, "Is it true?"
Then, "Is it needful?" In your mind
Give truthful answer; and the next
Is last and narrower: "Is it kind?"
And if to reach your lips at last
It passes through these gateways three,
Then you may tell the tale, nor fear
What the result of speech may be.

—From *The Arabian*, quoted in *The Rainbow.*

It is highly desired that members strive to conform to the above quoted advice. That there is a need for hesitancy and reflection in "What did you say" and how you said things, is evidenced by the increasing number of malpractice suits. In one county a 300 per cent increase in suits filed is recorded for the past year. Insurance companies are increasing rates and some are withdrawing coverage in certain counties and areas.

Primarily, many suits can be characterized as being wholly without merit, but masked in legal formalities and inspired by nonscrupulous lawyers, often sought and "worked up" by a lawyer. Next they are inspired by some physician who with premeditation utters to a patient derogatory comment upon the treatment rendered by another physician for revenge or spite. The seed is sown and the patient hurries to a lawyer, and suit is initiated. Many suits originate from remarks and comments spoken in a careless and casual way—call it a slip of the tongue if you wish.

These factors account for the increasing number of malpractice suits in this State. If physicians would refrain from thoughtlessly criticizing before or to patients the services rendered by another physician; if physicians would cease aiding attorneys in building up cases having no merit; if physicians would decline to testify against another physician unless the evidence clearly indicated malpractice—if these three 'dont's" were lived up to there would result a rapid decrease in the number of suits.

The plea is made that every member make it a point to so conduct himself and observe this manner of conduct.

* * *

CONVENTION PLACE 1937

Before submitting recommendations to the House of Delegates as to cities where accommodations are adequate for holding our annual session, the Council makes an investigation as to local facilities. In order that this may be done, county societies desiring to be hosts for the 1937 annual session are requested to send their invitations to the State Secretary before March 15. The invitation should be accompanied by a statement imparting hotel accommodations, meeting auditoriums, exhibit halls, and attraction features.

KERN COUNTY HOSPITAL DECISION

On January 31 the Fourth District Court of Appeals rendered a decision sustaining the Kern County Superior Court in determining that county supervisors could only hospitalize indigent cases in county hospitals. Full comment on this ruling and opinion will appear in our next issue.

* * *

ANNUAL DUES

Dues for 1936 are now payable. If you have not sent in your check, will you not please do so today? Your county and state membership is a valuable asset. Do not permit it to lapse. Help lessen the work of your county secretary by prompt payment of your dues. Then go a bit farther by securing the affiliation of that associate who is eligible for membership. Invite him to accompany you to a meeting and tell him why he should join. Our 1936 goal is 6,000 members. Will you help us to attain it?

* * *

COME UP AND SEE US

The editor of the *Journal of the Indiana State Medical Association* has seen fit to reprint the following paragraph.

The first impression the observant medical man gets in California is that there are more superannuated candidates for the cemetery than to be seen in any other section. Their presence depresses and haunts you! Go to California to live? Go there to die!!

No comment is made by the editor, but the inference can be perceived. In response the following is reprinted from our January issue:

An eastern surgeon, a university regent, and a man who has visited many clinics and medical meetings, not only in this country but all over the world, wrote in a personal communication:

"After leaving San Francisco, Mrs. S. and I went to Southern California, gaining impressions of the country in general and medical conditions in particular. Incidentally, we met a great many old friends and had a thoroughly enjoyable and profitable time. I came home with renewed and fresh impressions of the excellence of the medical service performed by the good men of the profession out there. Certainly your standards are as high as any in the country and far better than in most parts of the country, and I think all of you there can be well satisfied with what you are doing. There is a certain newness and freshness, a tendency to break away from restricting traditions, and an enterprising spirit which is very apparent to one who visits California after a period of years."

If eastern men would do as this surgeon did, come and spend two or three weeks in California, see and mingle with our members and gain first-hand information—well, eyes would see the light and there would be a new and better understanding.

To those of the profession who live and die east of the Rockies, we extend a cordial invitation to "Come up and see us." And to you in Indiana we assert that if you want to be "depressed" and "haunted" do not come to California, but visit and live in South Bend, Gary, Indiana Harbor, Hammond, with their barren sand dunes, swamp marshes, smoke, odor, and inhabitants of foreign birth. But if you desire to gain a new inspiration, to rid yourself of "depression" and "haunts"—come up and see us in California and learn whereof you comment. (Other editors please copy this *friendly* retort to our Indiana and Nebraska friends.) Afterthought: If you desire to die *young*, remain east of the Rockies. In California you *live* to a ripe old age midst pleasant lines and places—where men of eighty-five years root enthusiastically without pessimism. (Now it is your turn.)

MINUTES OF SECRETARIES' CONFERENCE

On January 18 the first annual conference of county secretaries was held in San Francisco. Every county organization except one was represented. The representative from Humboldt County, much to his regret, was unable to reach San Francisco by reason of heavy rains and obstructed roads. In addition to the secretaries, all the State Association officers and majority of the Council were present.

The announced program was followed. Each speaker presented valuable, useful information and advice related to organizational work, policies, and problems. The discussions clarified and advanced the features and purposes of organization. A stenographic record of the conference is being transcribed, and will be published in the March issue.

All in all it was a red-letter day in the history of our Association. County secretaries are our key men. It is they who cause our county units to apply policies and unite members into a centralized body for the purpose of attaining all ends and objectives of organizational endeavor. At this conference these key men obtained a better understanding of the purposes of organization. They returned home enlightened and imbued with the responsibilities of their office. It can be confidently assumed that as they report to their fellow members, all of our county organizations will reveal an awakened activity that will record enhanced benefits to all members.

The Council greatly appreciates the time contributed by these secretaries in attending this conference. Members are urged to coöperate with their county officers, to the end that there may be witnessed a bigger and better State Association. Watch for the March issue for detailed report.

* * *

PIONEER PHYSICIANS IN SISKIYOU COUNTY

An interesting bit of history by a member who has been in practice fifty-eight years:

Dear Doctor Warnshuis:

Noticing a reference to myself in the November number of CALIFORNIA AND WESTERN MEDICINE (Vol. 43, No. 5, p. 372), and to some physicians whose fate I knew, I pass on to you the items:

Dr. Ridgeley was a middle-aged man when he practiced in Sawyers Bar, Siskiyou County, in the early 70's. Fate unknown.

Dr. Cabaniss, a Civil War surgeon, practiced at Fort Jones, California, in the early 70's. His son is, or was, a judge in Alameda County.

Dr. Furber died in Etna, also in the early 70's.

Dr. S. S. Harwood (a former Guy's Hospital student) died in the late 80's.

Dr. Helm died in Sawyer's Bar in the 90's.

Dr. Jewell died in Fort Jones in the late 80's.

Dr. McCash practiced in Sawyer's Bar early in 1877. Left and I know no more of him.

Dr. McNulty died in Yreka about 1917. Date known by Dr. Jones.

Dr. Ream died in Yreka. Date known by Dr. J. Roy Jones.

Dr. Smith died near Etna in the 80's.

Dr. Wadsworth dead. Dr. J. Roy Jones can give data.

Dr. Cowan died in Fort Jones. Dr. J. Roy Jones can give data.

Drs. Nutting and Tebbe, deceased, were former Etnaites; the former died in Etna, the latter in Weed, California.

The first medical society in Siskiyou County was organized some time in the 80's. As Siskiyou County Medical Society, it was affiliated with the State Society and both Dr. Nutting and myself were members. Owing to the difficulties of travel it lapsed into innocuous desuetude, but later reorganized and joined the State Society. When I came to Siskiyou County the railroad only reached Redding; much of our travel was over trails (all of mine until 1882). I commenced in Sawyer's Bar in 1877, later moving to the next town—Etna. I have stayed in Etna; still practice, drive my own auto, am health officer, and enjoy perusing CALIFORNIA AND WESTERN MEDICINE.

Yours fraternally,

E. W. BATHURST, M. D.

"AMERICAN FOUNDATION STUDIES IN GOVERNMENT"

The following letter from the director of the Bureau of Economics of the American Medical Association should be of interest:

A considerable number of physicians throughout the United States have already received letters from the American Foundation Studies in Government requesting that they give their views informally on the present methods of medical practice and the degree to which medicine is now fulfilling its functions.

It was stated by Miss Esther Everett Lape, member in charge, that the Foundation has nothing to prove or to demonstrate to the Foundation Board. Miss Lape claimed, furthermore, that the information requested in the letters sent the physicians is not to be a statistical study; that neither the Foundation members nor the staff in charge have any preconceived notions, plans, programs or propaganda; that the study is to be confined to an endeavor to secure from practicing physicians statements of the factors involved in medical practice, opinions as to the extent to which the practice of medicine is fulfilling its functions, and expressions of the manner in which deficiencies or shortcomings in medical practice may be corrected if, and where, found. Miss Lape informed me that the Foundation desires to secure honest, complete, and well-considered statements; and that the correspondents' names will be withheld when desired. A considerable number of replies have already been received, and thus far the majority of the replies have given permission to use their statements in any legitimate way.

It appears, from Miss Lape's statements, that the compilation of the list of physicians to be circularized has not been completed and, therefore, all states have not yet been covered, but thus far about three thousand letters have been sent out. The returns, to date, number about 10 per cent of the letters mailed. It is expected that a much larger return will be received since many physicians have asked for more time in which to formulate their replies. The final list of physicians may reach ten thousand, more or less.

The final summary and digest of opinions and ideas will be prepared as a report to be sent to the correspondents whose material is used in the report for an examination prior to the release for publication.

Miss Lape, member in charge, expressed several times during the conference her anxiety over the activities of the small group in Washington which is attempting to change completely the existing social order. She expressed feelingly deep concern over the possibility of extending these reforms into the field of medicine. She was frank in expressing her opinion that some of these reforms might be merely a passing fancy, but if applied to medicine would result in a much greater social disaster than in other fields.

Information was offered by Miss Lape to the effect that the American Foundation has been engaged in other studies, such as the press poll of views of the World Court and views on Russian recognition. In each of these studies the Foundation has reported faithfully the views expressed by the writers, but at no time has it organized any propaganda or sought any objective except to present in an educational or informative way the actual uncolored facts or opinions.

Miss Lape wished it to be understood that the American Foundation's present undertaking to secure information from physicians is a bona fide effort to study certain phases of the economics of medicine by a method that has not been previously used. She stated that the Foundation is not so much interested in particulars, *per se*, as it is in the attitudes and opinions of physicians who can speak from experience on the way in which medicine is practiced and the manner in which it is meeting its obligations. Miss Lape assured me that there were no interests in the American Foundation seeking to forward any new theory or revolutionary scheme.

Miss Lape assured me that she and the American Foundation desire to keep in close contact with the American Medical Association and will welcome any suggestions, criticisms or assistance in the present study. She stated that the Foundation will be glad to answer any questions and will place the study in the Association's hands for examination if desired.

This is a report of statements made to me by Miss Esther Everett Lape and contains none of my personal opinions.

R. G. LELAND, M. D.,
Director, Bureau of Medical Economics.

POLL ON HEALTH INSURANCE

The tables impart the segregated vote by county tabulation of the returns upon the following questions submitted to the licensed physicians of California.

Questions:

1. Shall the California Medical Association endorse any legislative change in the present system of medical practice?

2. Are you in favor of compulsory health insurance?

3. Are you in favor of voluntary health insurance?

(*a*) Voluntary health insurance under a plan carried on by the State of California?

(*b*) Voluntary health insurance carried on by lay companies under legislative control.

(*c*) Voluntary health insurance carried on by some form of organization of licensed physicians of California, created by legislation?

4. Are you a member of the California Medical Association?

Interpretation of these returns can now be formulated by the individual member. The returns present an interesting picture of the composite opinion of the licensed physicians and surgeons of California.

HAPPENINGS OF THE MONTH

1. Council meeting, January 19. See important items in the minutes published in this issue, on page 120.

2. Committee on Public Relations. See report in Department of Public Relations in this issue of a conference held with representatives of medical staffs of hospitals on the question of hospital insurance. Your constructive recommendations will be welcomed.

3. San Diego Fair. Association accepts control and supervision of a separate building containing 22,000 square feet exhibit space, to be known as the Hall of Medical Science. In coöperation with the San Diego County Medical Society an outstanding educational exhibit of scientific medicine and preventive medicine is being prepared.

4. Plans for an Association sponsored program for malpractice insurance is being developed. Doctor Reinle's committee will present a full report to the House of Delegates.

5. Read editorials, Association news, and Department on Public Relations for important details of actions that are of vital interest to every member.

Result of Vote on Referendum No. 2

I. By Members of the California Medical Association

County	Question No. 1		Question No. 2		Question No. 3		Question No. 3A		Question No. 3B		Question No. 3C		No. of Members
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Alameda	76	73	21	136	108	42	7	72	13	73	97	25	172
Amador	1	..	2	1	1	..	..	1	..	1	1	..	2
Butte	4	8	2	12	7	5	1	5	1	4	7	2	13
Calaveras	1	1	1	1	..	1	..	2	..	2	1	1	2
Colusa	1	1	..	2	2	..	..	..	..	..	2	..	3
Contra Costa	4	2	1	6	3	3	2	2	1	2	4	1	9
Del Norte	2	..	2	..	1	..	..	..	..	1	1	..	2
Eldorado	1	1	1	1	1	1	..	2	..	2	2	..	2
Fresno	8	11	4	11	11	6	1	8	1	9	11	4	22
Humboldt	6	6	2	8	5	4	3	3	..	7	6	3	12
Imperial	3	5	2	7	2	6	..	4	3	1	2	3	10
Inyo	1	..	..	1	1	..	..	1	..	1	1	..	1
Kern	7	9	6	10	5	10	2	6	..	8	6	6	17
Kings	5	3	2	5	1	5	..	2	..	2	2	1	8
Lake	2	1	1	2	..	1	..	..	1	..	..	..	3
Lassen	1	..	1	..	1	..	1	..	..	1	..	..	1
Los Angeles	272	402	103	477	417	237	59	288	53	290	397	107	732
Madera	2	..	..	1	2	..	1	..	..	1	2	..	2
Marin	5	8	4	7	10	5	3	3	..	4	9	2	17
Mariposa	1	..	..	1	1	..	..	1	..	1	1	..	1
Mendocino	2	..	1	3	3	..	..	2	1	1	2	..	4
Merced	3	8	1	8	5	5	..	2	1	3	4	2	11
Modoc	..	..	..	..	..	..	..	..	..	..	..	..	..
Mono	..	1	..	1	1	..	1	..	1	..	..	..	1
Monterey	6	..	3	3	3	2	..	4	..	4	3	..	6
Napa	1	9	..	9	5	3	..	7	..	7	8	2	13
Nevada	..	3	1	3	1	1	..	1	1	1	1	..	4
Orange	12	18	4	26	19	12	3	8	3	13	17	4	33
Placer	5	6	2	7	5	2	..	4	..	4	5	..	11
Plumas	1	1	..	1	2	..	..	1	..	1	2	..	2
Riverside	12	17	1	31	20	13	3	10	2	12	16	6	33
Sacramento	10	37	3	44	26	23	6	14	6	15	18	7	51
San Benito	2	1	1	3	1	2	..	1	1	..	1	1	4
San Diego	41	77	11	110	64	54	15	45	5	54	60	27	148
San Francisco	153	140	174	99	138	110	19	114	25	107	135	38	319
San Joaquin	9	18	5	21	19	7	4	11	1	13	17	3	30
San Luis Obispo	10	16	2	21	14	5	3	6	..	9	17	2	26
San Mateo	3	3	1	4	4	..	..	3	..	3	4	..	6
Santa Barbara	22	23	13	30	29	12	3	18	2	17	25	8	51
Santa Clara	23	29	21	34	31	17	5	18	5	18	31	7	66
Santa Cruz	6	6	2	10	9	3	1	3	2	3	6	1	12
Shasta	..	3	1	1	..	2	..	1	..	1	..	1	3
Sierra	1	1	..	2	1	..	..	2	..	2	2	..	2
Siskiyou	4	3	1	4	6	1	..	6	..	5	5	1	7
Solano	4	2	1	3	3	2	1	4	..	4	2	3	6
Sonoma	8	10	4	16	12	6	6	7	..	11	8	7	20
Stanislaus	1	4	..	4	2	3	..	3	..	3	3	2	6
Tehama	..	2	..	2	1	1	..	1	..	1	1	1	2
Trinity	..	1	..	2	2	..	..	2	1	1	1	1	2
Tulare	6	11	3	11	6	7	2	2	..	2	5	..	17
Ventura	10	5	3	14	14	3	1	12	..	12	14	..	17
Yolo	2	4	3	4	4	3	1	3	..	4	1	2	7
Yuba	3	5	1	8	4	3	1	1	2	1	2	1	9
San Bernardino	23	29	7	48	39	11	4	26	7	21	31	12	56
Total	746	1,026	424	1,276	1,265	639	159	702	139	751	429	171	2,014
*Miscellaneous votes	37	35	21	49	34	24	12	24	4	28	28	14	75
	783	1,061	445	1,325	1,299	663	171	726	143	779	457	185	2,089

* Out-of-town members, unreadable cancellation marks, etc.

ELECTION OF A. M. A. AND C. M. A. OFFICERS: ANSWERS TO A LETTER

The following questions were received from a San Joaquin member. The answers sent him are published for the information of other members.

Q. Who elects the delegates to the American Medical Association and from what body are they chosen?

A. County societies elect from their membership one delegate for every fifty or major portion thereof of local members. These delegates constitute the House of Delegates of the State Association. The House of Delegates of the State Association elect the state delegates to the American Medical Association from the state members who have been fellows of the American Medical Association for a period of two or more years. California has seven national delegates who, with delegates from other states, constitute the American Medical Association House of Delegates. That body is limited to 175 delegates.

Q. Who elects the officers of the American Medical Association, and from what body are they chosen?

A. The House of Delegates, upon nominations made on the floor, elect the American Medical Association officers from those who are fellows of the Association.

Q. Who appoints the editor of the *Journal of the American Medical Association?*

A. The Board of Trustees appoints the editor. The Board of Trustees, nine in number, is the interim governing body of the national organization. It convenes four times a year. It has an Executive Committee that convenes monthly.

Result of Vote on Referendum No. 2

II. By Non-Members of the California Medical Association

County	Question No. 1		Question No. 2		Question No. 3		Question No. 3A		Question No. 3B		Question No. 3C		No. of Voters
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
Alameda	20	24	10	31	22	13	10	6	3	12	17	6	49
Amador	..	..	..	..	..	..	..	..	..	..	..	..	..
Butte	1	..	..	1	1	..	..	..	..	..	1	..	1
Calaveras	..	..	..	..	..	..	..	..	..	..	..	..	..
Colusa	..	..	..	..	..	..	..	..	..	..	..	..	..
Contra Costa	1	..	1	..	..	..	..	..	..	..	..	..	1
Del Norte	..	..	..	..	..	..	..	..	..	..	..	..	..
Eldorado	1	..	..	1	1	..	..	1	1	..	..	1	1
Fresno	6	3	2	4	5	2	1	4	..	3	4	..	9
Humboldt	1	1	..	2	2	1	1	..	..	1	2	1	5
Imperial	..	..	..	..	..	..	..	..	..	..	..	..	..
Inyo	..	1	1	1	..	..	..	..	..	..	..	..	2
Kern	1	3	..	5	3	2	..	3	1	2	2	2	5
Kings	..	1	..	1	..	1	..	..	..	..	..	..	1
Lake	..	1	..	1	..	1	..	..	..	..	..	..	1
Lassen	1	..	1	..	1	..	1	..	..	1	..	..	1
Los Angeles	113	185	58	242	149	120	31	105	36	104	112	64	351
Madera	..	1	..	1	..	1	..	..	..	..	..	..	1
Marin	..	1	..	1	1	1	1	..	..	..	..	..	2
Mariposa	1	..	..	1	1	..	..	1	..	1	1	..	1
Mendocino	2	1	3	2	..	3	1	..	..	..	1	..	5
Merced	..	1	3	..	..	..	..	..	..	..	..	..	1
Modoc	1	1	..	2	1	..	..	..	..	..	..	..	2
Mono	2	..	..	..	2	1	..	..	..	..	2	..	2
Monterey	1	1	1	1	1	1	..	1	..	1	1	..	2
Napa	..	2	1	1	1	..	1	..	..	1	..	1	3
Nevada	1	..	1	..	..	..	..	..	..	..	..	..	1
Orange	1	4	..	4	2	1	2	3	2	3	2	..	6
Placer	1	2	..	3	2	1	..	..	..	..	2	..	3
Plumas	..	..	..	..	..	..	..	..	..	..	..	..	..
Riverside	3	6	1	5	5	3	..	2	..	2	6	..	9
Sacramento	2	4	..	5	3	3	1	1	..	1	2	1	6
San Benito	..	1	..	1	..	1	..	..	..	..	..	..	1
San Bernardino	..	4	1	4	2	1	..	1	..	..	..	2	5
San Diego	12	22	10	27	14	15	3	11	2	12	14	8	43
San Francisco	46	53	21	80	48	43	9	36	10	31	40	15	116
San Joaquin	6	7	..	10	9	4	..	4	1	3	8	1	14
San Luis Obispo	1	5	..	4	3	2	..	3	..	3	3	1	6
San Mateo	..	3	1	2	2	2	1	..	1	..	1	1	4
Santa Barbara	1	1	..	2	2	..	1	..	..	..	1	..	4
Santa Clara	9	3	2	10	9	1	1	6	2	5	3	3	16
Santa Cruz	..	2	1	1	..	1	..	..	..	..	..	..	2
Shasta	1	3	1	3	2	2	..	2	..	2	2	..	4
Sierra	..	..	..	..	..	..	..	..	..	..	..	..	..
Siskiyou	..	..	1	..	..	..	..	..	..	..	1	..	1
Solano	..	4	..	6	1	4	1	1	..	2	1	2	6
Sonoma	2	1	1	1	1	1	.	..	..	..	1	..	3
Stanislaus	..	1	..	1	1	..	..	1	..	..	1	..	1
Tehama	..	..	..	..	..	..	..	..	..	..	..	..	..
Trinity	1	1	..	1	1	..	..	1	..	1	1	..	2
Tulare	2	..	..	3	2	1	1	1	1	..	1	..	3
Ventura	2	2	1	3	3	1	1	2	1	1	3	2	6
Yolo	2	..	1	1	1	..	..	1	..	1	1	..	2
Yuba	..	..	1	..	..	..	..	..	..	..	..	1	1
Total	245	357	122	468	207	232	68	194	59	190	143	112	709
*Miscellaneous votes	15	20	10	26	22	10	5	13	2	9	17	3	35
	260	377	132	494	229	242	73	207	61	199	160	115	744

* Out-of-town physicians, unreadable cancellations, etc.

Referendum No. 2: Summary

Total Vote

	Yes	No
1. Shall the California Medical Association endorse any legislative change in the present system of medical practice?	1,043	1,438
2. Are you in favor of compulsory health insurance?	577	1,819
3. Are you in favor of voluntary health insurance?	1,265	905
A. Voluntary health insurance carried on by the State of California?	244	933
B. Voluntary health insurance carried on by lay companies under legislative control?	204	978
C. Voluntary health insurance carried on by some form of organization of licensed physicians of California created by legislation?	617	300
4. Are you a member of the California Medical Association?	2,089	744

COUNCIL MINUTES

Minutes of the Two Hundred and Fortieth Meeting of the Council of the California Medical Association

The following minutes were approved by the Council by mail vote.

Held in Room 214, Sir Francis Drake Hotel, San Francisco, Sunday, January 19, 1936, at 9 a. m.

1. **Call to Order.**—The meeting was called to order by Vice-Chairman Morton R. Gibbons, with the following members present: President Robert A. Peers, President-elect Edward M. Pallette, Speaker W. W. Roblee, Councilors Karl L. Schaupp, Carl Howson, Henry J. Ullmann, A. E. Anderson, A. L. Phillips, Henry S. Rogers, C. L. Emmons, Morton R. Gibbons, W. H. Kiger, C. E. Schoff, C. O. Tanner; Chairman of Public Relations Committee Charles A. Dukes, Editor George H. Kress, Secretary F. C. Warnshuis, and General Counsel Hartley F. Peart. T. Henshaw Kelly and O. D. Hamlin arrived after the meeting had convened.

Absent: Harry H. Wilson.

2. **Delegates to the American Medical Association.**—Junius B. Harris, on account of the press of other duties, submitted his resignation as delegate to the American Medical Association, as follows:

"*To the Council.*—I hereby tender my resignation as delegate to the American Medical Association for the session of 1936, to take effect immediately.

(Signed) J. B. Harris."

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Kiger, that the resignation of Doctor Harris be accepted. Carried.

On nomination of President-elect Pallette, seconded by President Peers, F. C. Warnshuis was elected delegate to the American Medical Association for the 1936 session of the House of Delegates, in accordance with constitutional provisions.

Chairman of Public Relations Committee Dukes stated that he believed it would be impossible for him to attend the 1936 American Medical Association session and asked that his resignation be considered.

It was moved by Councilor Schaupp, seconded by Councilor Ullmann, that the resignation of Doctor Dukes as delegate to the American Medical Association be referred to the Executive Committee for consideration and action. Carried.

At this point Chairman Kelly took the chair.

2a. **Redistricting Councilor Districts.**—It was moved by Councilor Gibbons, seconded by Chairman of Public Relations Committee Dukes, that a committee of three be appointed from the Council to study the matter of redistricting councilor districts of the State and report to the Council, which shall submit recommendations thereon to the House of Delegates at the next meeting. Carried. (The committee appointed consisted of Doctors Rogers, Schoff, and Ullmann.)

3. **Ross-Loos Appeal.***—The secretary read the opinion and decision of the Judicial Council of the American Medical Association sustaining the appeal of Clifford Loos and Donald Ross.

It was moved by President Peers, seconded by Councilor Gibbons, that the secretary be instructed to send a copy of the decision to the Los Angeles County Medical Association and to advise them that upon receipt of the dues of Doctors Ross and Loos, they will be considered as members in good standing in the California Medical Association. Carried.

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* EDITOR'S NOTE.—References to the Ross-Loos appeal were printed in the council minutes, as follows:

Vol. 42, No. 1 (January, 1935), page 48, items 8 and 10.
Vol. 42, No. 1 (January, 1935), page 50, item 1.
Vol. 42, No. 1 (January, 1935), page 54, item 30.
Vol. 42, No. 2 (February, 1935), page 130, item 10.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS

January 14, 1936.

F. C. Warnshuis, M. D.,
Secretary, California Medical Association,
San Francisco, California.

Dear Doctor Warnshuis:

Please find enclosed the official opinion of the Judicial Council of the American Medical Association in the case of the appeal of Dr. H. Clifford Loos and Dr. Donald Ross from the decision of the Council of the California Medical Association affirming the action of the Los Angeles County Medical Society, by which action Doctors Loos and Ross were expelled from membership.

Yours very sincerely,

(Signed) OLIN WEST.

* * *

Opinion and decision of the Judicial Council of the American Medical Association in the case of the appeal of Dr. H. Clifford Loos and Dr. Donald Ross from the decision of the Council of the California Medical Association affirming the action of the Los Angeles County Medical Association expelling said members from membership therein.

The authority of the Judicial Council in the appeal of Doctors Loos and Ross and similar cases is clearly outlined and delimited in the by-laws of the American Medical Association, Chapter IX, Section 1, in the following words:

"The judicial power of the Association shall be vested in the Judicial Council, whose decision shall be final. . . . In all cases which arise . . . (c) between a member or members and the component society to which said member or members belong . . . the Judicial Council shall have appellate jurisdiction in questions of law and procedure, but not of fact."

The above constitutional limitation on any review of the merits of a case therefore prevents the Judicial Council from expressing any opinion as to the guilt or innocence of the appellants in connection with any unethical practices alleged and charged against them.

Therefore, the questions upon which this Council must render the decision are: (1) Were the appellants properly and lawfully apprised of and charged with an offense; (2) were they properly and lawfully tried; and (3) were the procedures fair, just, and without material error.

The provisions for the disciplining of members appearing in the by-laws of the Los Angeles County Medical Association are as follows:

"Article 2, Section 5. Whenever a member of this Association is charged with a criminal offense or gross misconduct, either as a physician or as a citizen, or is charged with the violation of any of the provisions of the Articles of Incorporation and By-Laws, he shall be notified by the Board of Councilors to appear before that body within ten days to show cause why he should not be censured, suspended or expelled." "After a full hearing of the case, the Board of Councilors have power by a three-fourths vote to censure, suspend or expel the member without written or verbal explanation of its reasons, such action to be effective only after a right to appeal to the Council of the California Medical Association is given the accused."

The record shows and no denial by either appellant or respondent is made, that on a certain date the appellants were served with a notice to appear eleven days later before the Council of the Association to show cause why they should not be censured, suspended or expelled from membership. No statement of definite charges nor indication of the nature of any charges were contained in the summons. Upon receipt of the summons the appellants, by telephone, inquired from the secretary of the Association what the nature of the inquiry would be, whether they should bring their books or witnesses and whether they should be attended by their attorney. As stated by the secretary,

"the reply was in rough terms that the Council wanted to inquire into their relationship to advertising matter, particularly the circular that had just been circulated among the teachers of the Los Angeles County schools.

He asked me if they should bring attorneys, and I told him that usually the discussions before the Association were between members and the Council, and he asked should we want their books or witnesses, and I told him usually they were not brought, but that he could do as he wished." "My answers to him over the telephone were guided by an attempt to be as noncommittal and impersonal as I could."

Doctor Loos and Doctor Ross appeared as cited, and a report of the Association's Medical-Legal Committee was read in which definite charges were made, supported by direct statement of the committee, that the matters reported were true. Certain other matters were charged on the basis that "we are informed that." Doctor Loos and Doctor Ross denied all charges, explaining each one, and offered to bring legal evidence of the truth of their statements "if the Council wished." A general discussion developed during which matters not contained in the Medical-Legal Committee's report were included, after which Doctor Loos and Doctor Ross were excused. Following their retirement the Council voted to expel Doctor Loos and Doctor Ross, and also adopted the report of the Medical-Legal Committee.

It is a fundamental principle of American jurisprudence (1) that a person shall be considered innocent until he has been proved guilty; (2) that an accused person shall know of what he is accused; (3) that he shall have adequate opportunity to defend himself; (4) that he shall not be punished for an act not included in the charges against him; and (5) that he shall have a fair trial.

Every one of the above five principles was violated in the trial of this case before the Council of the Los Angeles County Medical Association. There is nothing in the record of this case and nothing in the hearing before the Judicial Council showing that these men had been proved guilty of anything covered by the report of the Medical-Legal Committee of the County Association.

No supporting evidence to that report was offered, and so far as the record shows, the committee, on the one hand, charged offenses and the appellants, on the other, denied them. The appellants at the time offered to submit proof of their denial, which later, in fact, they did in the form of sworn statements by officials of the organizations involved, which were presented in the appeal of the appellants to the California Medical Association. On the side of the Los Angeles County Medical Association was only circumstantial evidence sufficient to cause strong suspicion, but insufficient to convict.

No indications of what the charges were appeared in the summons to appear and show cause. The appellants tried to learn from the proper officer, the secretary of the Association, what the charges were. Instead of informing them, if indeed he knew since the report of the Medical-Legal Committee which constituted the charges was not adopted by the Board of Councilors until after the hearing was held, the secretary himself testified that he answered the inquiry "in rough terms that the Council *wanted to inquire* into their relationship to advertising matter." He also testified that in answer to the question as to whether the appellants should bring attorneys that "usually the *discussions* before the Association were between members and the Council." He carefully evaded any appearance of there being a formal trial and avoided telling them of what they were charged. They were, doubtless, lulled by the appearance of informality and dissuaded thereby from bringing supporting evidence to any statement they might wish to make by the absence of any charges in the summons and the evasiveness of the secretary in answering their inquiries as to the character of the charges. It is quite apparent that, whether guilty or not, they did not have a fair trial.

The by-laws of the California Medical Association, providing for the disciplining of the members of all its component county medical societies, are as follows:

"Chapter 11, Section 3. No member of a component county society shall be deprived of his membership unless by his own act, except by a two-thirds affirmative vote of all the active members in good standing of the component county society to which he belongs, present and voting at a regular meeting thereof, or by a two-thirds vote of its Council or Board of Directors, present and voting at a regular meeting thereof, and only after at least six weeks' written notice personally delivered to the member has been served upon him, fully stating the charges against him, and only after such member shall have been given full opportunity to be heard in his own defense at such meeting."

The by-law of the California Medical Association is explicit, fair, just, and does not offend the principle of proper protection of the rights of membership in the county, state, and national organizations. The similar by-law of the Los Angeles County Medical Association, on the contrary, is vague, unfair, arbitrary, and fails to give adequate protection to every member of that society. At any time a small group of members having obtained positions of authority may use such authority against any member said group elects to prosecute or persecute and the member has only the protection of a time-consuming, expensive appeal to the Council of the State Association or the Judicial Council of the American Medical Association.

The California Medical Association is the creative and authoritative body over the Los Angeles County Medical Association. The County Medical Association is a unit in organized medicine because of the charter granted it by the said State Association. Therefore a by-law of the county society inconsistent and in conflict with a similar one of the State Association is null and void. The by-law of the California Medical Association, previously quoted, provides that "no member of a component society" shall be deprived of his membership except as provided therein. This covers the membership of the Los Angeles County Medical Association as well as the membership of every other component society.

It is admitted by the respondents that the whole procedure in the Los Angeles County Medical Association was irregular and prejudicial to the interests of the appellants, that they were entitled to the protection of the by-law of the State Association, but that by answering the summons, attending the meeting as directed and defending themselves against the report of the Medical-Legal Committee, they waived those rights provided by the State Association by-law. The Judicial Council is not impressed by this argument. The record shows that several times previous to this action the appellants had been called before the Society's representatives for discussion and explanation of their operations; that at no previous time had such formal notice been given and, therefore, an effort was made to learn from the proper officer what matter would be brought up, in order to be properly prepared; that appellants were lulled by that officer's evasiveness; that because of that evasiveness they were not prepared to present denial supported by legal evidence, but that they offered to obtain such evidence; that, in fact, they did produce such sworn evidence before the Council of the State Association later on. If a claim of waiver is to be made, it is the obligation of the party making the claim to show that there was an intent to waive. Such an intent cannot be assumed simply because an accused cited to appear does so appear and make general denial, and especially if the accused offers to produce further evidence by witnesses not then available to support the denials.

For the following briefly summarized reasons, viz., (*a*) the appellants were brought to trial with no definite knowledge of what they were charged, (*b*) they had no adequate opportunity to defend themselves, (*c*) they were expelled for some unknown act not appearing in the charges, and (*d*) they did not have a fair trial, which appear in full in the above analysis, the Judicial Council supports the appeal of Dr. H. Clifford Loos and Dr. Donald Ross from the decision of the Council of the California Medical Association, which affirmed the action of the Los Angeles County Medical Association expelling said physicians from membership therein.

GEORGE EDWARD FOLLANSBEE, M. D.
WALTER DONALDSON
GEORGE NOLAND
JOHN H. O'SHEA

January 2, 1936.

4. **Kern County Membership Appeals.** — The secretary read the notice of appeal from the action of the Kern County Medical Society Board of Directors expelling Joe K. Smith from the Kern County Medical Society and suspending J. M. Kirby and R. M. Jones for a period of fifteen years, and H. H. Rogers for a period of five years,

signed by these physicians and filed in the office of the Association.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Schaupp, that a committee of the Council be appointed to exert proper efforts at conciliation and compromise in the matter of these expulsions and suspensions from the Kern County Society, prior to the hearing of the appeal. Carried. (The committee appointed consisted of Doctors Howson, Anderson, and Ullmann.)

5. **San Francisco County Membership Appeals.**—The secretary reported that notice of appeal from the action of the San Francisco County Board of Directors in suspending Ferd W. Callison for a period of fifteen years, and request for hearing relative to the suspension by the San Francisco County Society of Herbert J. Cohn for a period of ninety days, had been filed in the office of the Association.

It was moved by Councilor Kiger, seconded by Councilor Ullmann, that a special committee of the Council be appointed to exert proper efforts at conciliation and compromise in the matter of suspensions from the San Francisco County Medical Society. Carried. (The committee appointed consisted of Doctors Dukes, Hamlin, and Rogers.)

6. **Date of Next Council Meeting.**—It was moved by President-elect Pallette, seconded by Speaker Roblee, that the next meeting of the Council be held at the Sir Francis Drake Hotel, San Francisco, on Saturday, April 11, 1936, at 9 a. m., and that the hearing of the appeal of Kern County members be held at 10 a. m. of said day, and the hearings of appeals of San Francisco County Society members be held at 2:30 p. m. of said day. Carried.

7. **Conduct of Hearings.**—Chairman of Public Relations Committee Dukes raised the question as to whether or not members presenting appeals might be represented by attorneys at law.

After discussion it was the consensus of opinion of the Council that members desiring to be represented by attorneys might secure such services under the limitations set forth at the hearing by the chairman of the Council.

8. **San Diego Fair Exhibits.**—The secretary reported on the exhibit to be conducted under the auspices of the California Medical Association and the San Diego Society at the San Diego Fair, and read a letter from the American Medical Association signifying its willingness to exhibit if the supervision and control was under the medical association.

Clarence G. Toland, chairman of the Association's Committee on the San Diego Fair Exhibit, presented a detailed report on the proposed exhibits and a list of participants, and stressed the necessity of supervision of the entire exhibit by someone trained in the preparation and control of scientific exhibits.

It was moved by Councilor Ullmann, seconded by Councilor Kiger, that the California Medical Association offer the services of its secretary to the San Diego County Medical Society and the Fair Management in the development of a medical exhibit and that the expenses of the secretary be paid by the Association. Carried.

9. **Malpractice Insurance.** — George G. Reinle, chairman of the Committee on Medical Defense, submitted a detailed report on the present situation of medical defense and suggested that the Council appoint a committee to make a further study of the most desirable solution of the problem.

It was moved by Chairman of Public Relations Committee Dukes, seconded by Councilor Emmons, that the Committee of Medical Defense and such advisory committee as may be appointed by it, be authorized to make a further study of the matter. Carried.

The necessity of securing aid of a trained insurance man in collection of actuarial statistics was discussed, and on motion of Councilor Gibbons, seconded by President Peers, John G. Johnson Co. was authorized to make negotiations with various insurance companies and submit a plan for medical defense insurance.

The letter designating Mr. Johnson as broker follows:

John G. Johnson Company,
San Francisco.

Gentlemen:

You are hereby appointed by the Council of the California Medical Association the sole insurance broker of the Association to devise plans and to negotiate for medical malpractice insurance, including both legal defense and indemnification to cover members of the California Medical Association.

It is understood that this is without obligation to the California Medical Association, and that no plan or policy will be effective until approved in all details, in writing, by the Council of the California Medical Association. This appointment may be terminated as set forth in our letter of transmittal.

Yours very truly,

F. C. WARNSHUIS, *Secretary.*

* * *

John G. Johnson Company,
Russ Building,
San Francisco.

Gentlemen:

The Council of the California Medical Association hereby nominates and appoints you as its sole insurance broker upon the following terms and conditions and for the duration of time hereinafter stated.

1. *Services and Limitations:* In your capacity as insurance broker for the Council of the California Medical Association you are to devise plans of, and to negotiate for, insurance policies of such conditions and terms as to provide for the members of this Association, legal defense in the event that actions are brought against them for malpractice and to indemnify a member whenever such action results in a judgment for damages against him.

2. Acceptance of Policies, Terms and Premiums: Before any plan of form of malpractice insurance protection for the members is executed all the terms, conditions, procedures, coverage and policy provisions shall be submitted to the Council of the California Medical Association for its final endorsement and approval. It is specifically stipulated that this Council or any of the members of this Association shall not be under any obligation to you or any insurance carrier until final approval and agreement shall have been executed in writing by the Council.

It is further stipulated that the Council of the California Medical Association does not assume any financial obligation to you, or any insurance company for expenses that may be incurred by you or by them.

3. *Termination of Broker Service:* The Council hereby reserves the right to cancel your appointment as Association Liability insurance broker, upon written notice, whenever the Council deems that such cancellation is in the best interests of this Association and its members. It is hereby stipulated that in the event of such cancellation neither the Council of the Association nor any of its members shall be financially obligated for any services that you or your firm may have rendered.

COUNCIL OF CALIFORNIA MEDICAL ASSOCIATION.
By T. Henshaw Kelly, *Chairman.*
F. C. Warnshuis, *Secretary.*

Accepted:

10. **Review Books.**—It was moved by President-elect Pallette, seconded by Councilor Kiger, that all books sent to the Association for review be retained in the offices of the Association and that the magazines received in exchange be sent to the San Francisco County Society Library and that the previous monthly payment of $15 in lieu of rent be discontinued. Carried.

11. **Medical Society of New Jersey.**—A letter from the Medical Society of New Jersey regarding a special meeting of the House of Delegates of the American Medical Association on medical economics was read and placed on file.

12. **Practice of Radiology.** — A resolution from the Pacific Roentgen Club, supporting the action of the California Medical Association that holds that all branches of radiology are the practice of medicine, was read.

The secretary read the following resolution, which was presented by the Section on Radiology of the California Medical Association:

WHEREAS, Certain organized lay groups in this country are endeavoring to arrange for the provision of diagnostic

medical service along with and as part of hospital services; and

WHEREAS, The provision of such diagnostic medical services will inevitably foster fundamental changes in the practice of medicine; and

WHEREAS, Such changes in the practice of medicine may well result in deterioration of our present medical standards and especially in deterioration in the quality of medical care furnished to hospital patients; now, therefore, be it

Resolved, That it is the official policy of the House of Delegates of the American Medical Association that it disapproves of the division of any branch of medicine into technical and professional portions; and be it further

Resolved, That copies of this resolution shall be brought to the attention of the American Hospital Association and its affiliated groups, to the end that existing arrangements permitting division in medical practice be terminated as speedily as possible.

It was moved by Councilor Rogers, seconded by Councilor Ullmann, that the request of the Section on Radiology be complied with and that the delegates to the American Medical Association be requested to introduce this resolution at the 1936 Kansas City meeting of the House of Delegates. Carried.

13. **Association Correspondence.**—The secretary read a letter from Olin West stating that the California Medical Association letter of December 2, relating to negligence in replies to specific questions asked by this Association, had been received and would be referred to the Executive Committee and the Board of Trustees. The secretary reported that no further reply has been received to date.

14. **Lay Technicians.** — The proposed University of California Extension Course for training of lay technicians was discussed and, on motion of Editor Kress, seconded by Councilor Rogers, the matter was referred to the secretary for reference to the proper committee. Carried.

15. **Woman's Auxiliary.**—A letter from the chairman of the Committee on Associated Societies and Technical Groups asking, on behalf of the Woman's Auxiliary, for $150 for entertainment at the annual session, was read.

It was moved by Speaker Roblee, seconded by Chairman of Public Relations Committee Dukes, that $150 be given to the Woman's Auxiliary for entertainment at the annual session. Carried.

16. **Editor of the American Medical Association Journal.**—After consideration of clippings taken from the daily press and letter from a member of the Association, on motion of Councilor Kiger, duly seconded, the following resolution was adopted:

WHEREAS, The editor of the *Journal of the American Medical Association* is a paid employee of the Board of Trustees and the House of Delegates; and

WHEREAS, This employed editor has for some years been conducting a syndicated column in the local press of the country by writing articles on medicine, health and allied subjects over his name to which is appended the title of "Editor of the Journal of the American Medical Association and Hygeia," for which he receives financial returns to his own personal profit and gain; and

WHEREAS, The public gains the impression that in these articles the editor is the spokesman for the Association and its members and that the articles are endorsed by the Association; and

WHEREAS, Section XVI of the By-Laws provides that no memorial, resolution or opinion of any character whatever shall be issued in the name of the Association unless it has been approved by the House of Delegates; and

WHEREAS, Many of these syndicated articles of the employed editor of the Association have received adverse criticism and disapproval by lay and professional men because of their content, style and errors, thereby producing adverse reflection upon the Association; and

WHEREAS, The employed editor is not the spokesman of the Association or its members as he has at times stated and implied; now, therefore, be it

Resolved, That the Council and officers of the California Medical Association do hereby respectfully petition and request the Board of Trustees of the American Medical Association to take action to instruct the employed editor to immediately discontinue the use of the title "Editor of the Journal of the American Medical Association and Hygeia" after his name in his syndicated articles written for non-medical publications; and be it

Resolved, That the Board of Trustees of the Association be requested to take the necessary action that will prevent its employed editor from capitalizing upon his position and using it for his personal financial profit; and be it

Resolved, That the Board of Trustees require its employed editor to devote his entire time to the editorial duties of that office; and be it

Resolved, That the secretary of the California Medical Association be hereby instructed to send a copy of this resolution to the chairman and the secretary and members of the Board of Trustees, secretaries and editors of the State Associations and to all the members of the House of Delegates of the American Medical Association.

17. **Health Insurance.**—A detailed tabulated report on the poll taken of all of the licensed physicians and surgeons in California upon changes in laws governing medical practice in California was submitted, and on motion duly made, seconded and carried, the report was accepted, the committee thanked for its services, and the poll declared closed.

18. **Association Headquarters.** — The secretary presented correspondence regarding the acquisition of a permanent Association headquarters.

It was moved by Peers, seconded by Roblee, that a committee be appointed to study this matter from all angles and be authorized to take an option upon the property without any down payment, and report back to the Council. Carried. (The committee appointed consisted of Doctors Kelly, Pallette, Gibbons, Roblee, and Warnshuis.)

19. **Recess.**—At this point a recess was declared for luncheon.

20. **Call to Order.**—The Council was called to order by Chairman Kelly after the recess.

21. **Committee of Five.** — Correspondence was read from Dr. W. R. Molony, chairman of the Committee of Five, stating that Professor Dodd had advised him that all materials relating to the California Medical Association's part of the survey were being forwarded to the Association offices and that final revision of the report was now being made, which would complete his responsibility to the Committee of Five.

Discussion was then had of the matter of final revision and evaluation of the report. Doctor Yoell was granted the privilege of the floor, and stressed the desirability of securing the services of Professor Canning for a final revision of the report. Further discussion followed.

It was moved by Councilor Howson, seconded by Councilor Ullmann, that the matter be laid on the table for two hours. Carried.

22. **Secretary's Annual Report.**—The secretary presented his annual report to the Council as mailed to all members thereof.

It was moved by Councilor Ullmann, seconded by Councilor Kiger, that the report of the secretary be accepted for submission to the House of Delegates. Carried.

23. **Auditing Committee Report.** — The question of transportation expense was raised, and it was the sense of the Council that the present allocation of railroad fare and lower berth be abided by.

Excerpts from the audit of the Association's accounts as prepared by Ernst & Ernst, certified public accountants, were read. The allocation to the JOURNAL of $3 dues of the members in place of the former allocation of $2 was discussed in detail. It was pointed out that this accounted for a relative amount of loss in "Association" accounts and gain in "JOURNAL" accounts over the previous years.

It was moved by Councilor Gibbons, seconded by Editor Kress, that the accountants be requested to change the Association books to the type used by a nonprofit organization. Carried.

It was moved by Councilor Gibbons, seconded by Speaker Roblee, that the expense incurred by the president and the president-elect in visiting county societies be approved for payment by the Association. Carried.

24. **Scientific Sections of the Association.**—The secretary recommended, upon suggestion of the Scientific Committee and Section officers, that a study be made of the Scientific Sections of the Association with a view of reorganizing the same.

It was moved by President-elect Pallette, seconded by Phillips, that a committee survey this matter and report to the Council, who will in turn make recommendations for submission to the House of Delegates. Carried. (The committee appointed consisted of Morton R. Gibbons, L. A. Goin, L. P. Adams, John Ruddock, and Fred Gundrum.)

25. **Funds of the Association.**—It was moved by Councilor Kiger, seconded by Councilor Emmons, that the Association and revolving funds of the Association be deposited in the Crocker First National Bank.

26. **Budget.**—The chairman of the Auditing Committee submitted the budget of the Association for the year 1936-1937.

It was the sense of the Council that the expense of the various departments be broken down and shown each under one subheading in the budget.

It was moved by Councilor Gibbons, seconded by President-elect Pallette, that the budget as submitted with the emendations suggested be approved by the Council for submission to the House of Delegates. Carried.

27. **Qualifying Certificate Act.**—George H. Kress, chairman of the Special Committee on the Qualifying Certificate Act, submitted the minutes of the meeting of his committee, which was held on December 14, 1935.

It was moved by Editor Kress, seconded by Councilor Gibbons, that the proposed enactment of a qualifying certificate act by initiative petition be postponed until the November, 1938, election. Carried.

On motion of Pallette, seconded by Ullmann, the following resolution was submitted to the Council for action:

WHEREAS, The referendum vote of the California Medical Association members on a proposed Qualifying Certificate (Basic Science) law showed that about 90 per cent of the physicians who cast ballots were in favor of such initiative law; and

WHEREAS, Because of the new registration laws, an initiative cannot be submitted to the electorate until November, 1938; now, therefore, be it

Resolved, By the Council of the California Medical Association that the sum of $35,000 be set aside from the funds of the Association as a separate fund to be earmarked for use in the November, 1938, State election, at which time the proposed Qualifying Certificate Law will be placed on the ballot.

A vote on the question was called for, and there being a division of opinion Doctor Schoff called for a vote by roll call.

Noes: Doctors Peers, Roblee, Kelly, Schaupp, Emmons, Ullmann, Anderson, Phillips, Hamlin, Rogers, Tanner, Gibbons, and Harris.

Ayes: Doctors Pallette, Howson, Schoff, and Kiger.

There being thirteen noes and four ayes, the motion was declared defeated.

28. **Disciplinary Procedure.**—William Roblee, chairman of the Committee on Disciplinary Procedure, presented the report of his committee. The proposed by-laws embodying rules of ethics and procedure were then considered, section by section.

It was moved by Councilor Gibbons, seconded by Councilor Emmons, that any member of the Council who had further suggestions for the by-laws and rules for disciplinary procedure submit same to the committee within the shortest time possible, and that the committee submit a final report to the next Council meeting. Carried.

29. **Foreign Exchanges.**—On motion of Councilor Ullmann, seconded by Councilor Rogers, the Council directed that foreign exchanges be discontinued. Carried.

30. **Publication of Nevada Papers.**—The editor was authorized to use his discretion on publication of papers received from the Nevada Association, maintaining the same quality standard as is observed in acceptance of papers from California authors.

31. **Journal to American Medical Association Delegates.**—It was moved by President-elect Pallette, seconded by Councilor Kiger, that, for one year, CALIFORNIA AND WESTERN MEDICINE be sent to all members of the House of Delegates of the American Medical Association and to the American Medical Association trustees. Carried.

32. **Roster of Association.**—It was moved by Councilor Schaupp, seconded by Councilor Anderson, that a roster of members of the California Medical Association be published in the JOURNAL as heretofore. Carried.

33. **Special Societies.**—Discussion was had of the inclusion of special societies in the list of organizations published in the forepart of the JOURNAL.

On motion duly made, seconded and carried, it was ordered that organizations applying for such listing be advised that it is the policy of the Association not to publish lists of any special organizations.

34. **Complimentary Journals.**—It was moved by Editor Kress, seconded by Councilor Kiger, that Lionel Browne, attorney for the State Board of Health and the Board of Medical Examiners, be placed on the complimentary mailing list of the JOURNAL. Carried.

35. **Annual Session.**—The secretary stated that, due to illness, Dr. Tate Mason may be unable to attend the annual session as an invited speaker.

Full discussion was had of entertainment at the annual session.

It was moved by Councilor Gibbons, seconded by Councilor Ullmann, that the matter of expenditure for entertainment at the annual session at Coronado be left in the hands of the secretary and the local Committee on Arrangements. Carried.

36. **Public Relations Department.**—The secretary reported for the committee chairman that the Committee on Public Relations and representatives of the various hospitals in California had met and discussed hospital service under Assembly Bill 246 and that the hospital representatives and the radiologists are to form a committee to meet with the Public Relations Committee for the purpose of formulating a state policy regarding hospital and laboratory services in connection with hospital insurance.

37. **Committee of Five.**—It was moved by Councilor Ullmann, and seconded by Councilor Gibbons, that the matter of securing the services of Professor Canning to assist in the final revision of the survey report be removed from the table.

Doctor Schoff stated that he wished to go on record as suggesting to the Committee of Five that Doctor Canning be employed, but that the matter be referred back to the Committee of Five for any action.

It was moved by President-elect Pallette, seconded by Councilor Emmons, that the matter of securing the services of Professor Canning be returned to the table. Doctors Schaupp and Gibbons voted in the negative. There being a division of opinion the chair called for a vote by roll call.

Ayes: Doctors Pallette, Roblee, Emmons, Howson, Ullmann, Anderson, Phillips, Hamlin, Kiger; Harris (with right to explain his vote).

Noes: Doctors Kelly, Schaupp; Schoff, qualified with "No" on tabling because he wants to have the matter go back to the Committee of Five; Rogers, Gibbons.

Ten votes to table being cast in the affirmative and five in the negative, the matter of securing the services of Doctor Canning was returned to the table.

Doctor Harris then explained his affirmative vote, stating that he did not wish to bury the report, but that he thought this was the wrong time to employ Professor Canning and that he believed this matter should go back to the Committee of Five and that a stimulating committee should be appointed to act with the Committee of Five.

It was moved by Councilor Harris, seconded by President-elect Pallette, that a committee of three, consisting of Doctors Kelly, Pallette, and Roblee, be appointed to

act with the Committee of Five, to the end that this survey report be placed in its final form at the earliest possible moment. Carried.

38. **Legal Department.**—The general counsel reported on the present status of the case of *Pacific Employers* vs. *Insurance Commissioner*, and *Francis* vs. *Nelson*.

The general counsel stated that he had received a letter from the American Medical Association wherein Doctor Woodward did not agree with the contentions made by the California Medical Association regarding exemption of physicians from income tax.

39. **Farm Bureaus.**—Doctor Rogers outlined activities of the various Farm Bureaus and stated that speakers had been furnished for lay meetings on several occasions and that through the coöperation of the secretary additional speakers would be furnished in the future.

40. **Tax-Supported Hospitals.** — Dr. Anderson, chairman of the Committee on Tax-Supported Hospitals and Medical Services, stated that the committee was gathering information and that questionnaires had been received and were now ready for tabulation and that a further progress report would be submitted.

41. **Cancer Commission Report.**—Dr. Ullmann stated that many requests had been received for copies of the report of the Cancer Commission and that the Commission desired to have additional reprints made for resale at 75 cents per copy.

It was moved by Councilor Ullmann, seconded by Councilor Harris, that the secretary of the Association be authorized to secure reprints of the report of the Cancer Commission on the basis of the bid submitted by Stacey, subject to the approval of the Auditing Committee of such expenditure of funds. Carried.

42. **Adjournment.**—There being no further business, the meeting adjourned.

T. Henshaw Kelly, *Chairman.*
F. C. Warnshuis, *Secretary.*

COMPONENT COUNTY MEDICAL SOCIETIES

FRESNO COUNTY

The months of December and January have been busy days for the officers and members of the Society. Under the leadership of our new president, Dr. Kenneth Staniford, several new projects have been launched by the Society. The Woman's Auxiliary has been definitely organized and is now under way as an important aid to the Society.

On December 12, 1935, the Board of Directors met in special session with representatives of the American Red Cross. After listening to arguments from the Red Cross, the Board finally approved the organization of a well-baby conference, to be conducted in a section of Fresno where infant mortality is high and medical service inadequate. The Red Cross pledged a rigid social servicing of all applicants to the conference.

The regular meeting of the Society took place on January 7 at the University-Sequoia Club. Dinner preceded the meeting, which was well attended. Following the showing of some interesting African films by Mr. John Cooper, the scientific program was presented by Dr. Alson Kilgore of San Francisco. His subject was the *False Acute Abdomen*. Doctor Kilgore discussed in detail the differential diagnosis of the acute surgical and nonsurgical abdomen. His paper was intensely interesting and enjoyed by all those present.

On January 16 the Board of Directors again held a special meeting with the Committee on Hospitals and the Committee on Public Policy and Legislation. The purpose of this meeting, in the main, was to discuss the hospital insurance plan, which has again come to life by virtue of recent legislation in favor of this means to reduce the costs of medical care. The committees were instructed by the Board to review in detail the plan already approved by the Society some time ago, and if deemed feasible to report back with their recommendations to the next board meeting. It is then planned to present the proposed project to the Society, which, if approved, will be put in working form and offered to the public.

The Board of Directors, at this meeting, also went on record as endorsing the efforts of the local committee for the President's birthday ball in combating poliomyelitis, and instructed the secretary to give a radio address on January 18 relative to the Society's approval of the anti-poliomyelitis campaign.

Henry A. Randel, *Secretary.*

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HUMBOLDT COUNTY

The Humboldt County Medical Society held their regular meeting on the evening of December 18, 1935, at the St. Joseph's Hospital, President Charles C. Falk, Jr., presiding.

The applications of Francis H. O'Neil, Joseph M. Brown and Thomas F. Thorp, having been reported upon favorably by the State Society, were received into the local society. A resolution was passed and forwarded to Governor Merriam, urging the Governor to reappoint Dr. Charles B. Pinkham as a member of the State Board of Medical Examiners.

Ten-minute talks were given by the following members of the American College of Surgeons: Lane Falk, G. F. Norman, B. M. Marshall, O. R. Myers, and Charles C. Falk, Jr.

Election of officers for 1936 was held, with the following results: Joseph S. Woolford, president; Allan R. Watson, vice-president; John A. Lane, treasurer; Lawrence A. Wing, secretary; Lane Falk, delegate; Wilson Stegeman, alternate.

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The Humboldt County Medical Society held its regular monthly meeting on January 16 at the Eureka Inn. There were twenty members present, and two guests—Doctors Albert V. Pettit and George Ward of San Francisco. President J. S. Woolford presided, and Dr. Lane Falk was chairman of the day.

Due to the fact that reports of our monthly meetings did not get into the Journal more regularly, on motion we changed our regular meeting night from the third Thursday to the first Thursday, thereby giving time to get a report in the issue of the same month.

The Society was the guest of Dr. Lane Falk at a crab luncheon, followed at three o'clock by special pictures and discussion on the lower abdominal and pelvic cavities. In the evening at eight o'clock, Doctor Pettit, assisted by Doctor Ward, presented the main paper—*The Principles which Lie Behind Certain Operations of the Abdominal and Pelvic Cavities, as of the Suspension of the Uterus, Vaginal Suspension of the Stump, Trachelorrhaphy, Cystocele, Enterocele and Pelvic Inflammations.* Discussion of the above paper was given by Doctors O. R. Myers, Lane Falk, J. F. Walsh, and Charles Falk, Jr. The Society was very grateful to Doctors Pettit and Ward for putting on such a splendid program, especially due to the fact of facing such a storm, taking two days to reach Eureka.

The next meeting, in February, will be a joint meeting with the dentists. A speaker from the Public Health League will address us.

Lawrence A. Wing, *Secretary.*

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SACRAMENTO COUNTY

The regular annual business meeting of the Sacramento Society for Medical Improvement was called to order by the president, Orrin S. Cook, on the evening of December 17, 1935, at the Elks Temple. Thirty-five members were present.

Election of officers for 1936 resulted as follows:

Board of Directors—Doctors Cook, MacDonald, Van Den Berg, Ankele, Scatena, Wallerius, Hale, Dozier, and Pollock.

Delegates—Doctors Hale and Scatena were elected to serve as delegates for the years 1936 and 1937.

Alternates—Doctors Cook and Christmas were elected to serve as alternates for the years 1936 and 1937.

Dr. Norris R. Jones was elected secretary-treasurer.

Moved and seconded that Dr. W. K. Lindsay be made an honorary member of this society, subject to action by the California Medical Association. Passed.

FRANK WARNE LEE, *Secretary.*

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SAN BERNARDINO COUNTY

The meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, January 7, at 8 p. m. The meeting was called to order by the president. About seventy-five members and guests were present.

The president called attention to the special meeting with the Riverside County Medical Society on January 13 for the purpose of meeting with the State Association officers.

The following names were voted on and approved for membership: Drs. Clarence W. Dail, Aumond D. Meyers, and Edwin H. Shryock. Loma Linda; Marcus D. White, Ontario.

Mr. H. P. Thoreson, County Director of SERA, spoke briefly on the shortage of funds, beyond their control, and asked the panel physicians to coöperate in every way to help control expense.

The secretary announced the unfortunate and untimely death of Dr. John A. Graham of Barstow. The following resolution was approved:

WHEREAS, It has pleased the Almighty God to take from our midst our beloved and highly respected colleague, Dr. John A. Graham; and

WHEREAS, This Society feels most deeply the loss of one of its outstanding members; now, therefore, be it

Resolved, That the San Bernardino County Medical Society extend to the bereaved family this expression of its deep sorrow and most sincere and heartfelt sympathy, and that this resolution be spread upon the minutes of the Society.

The program of the evening was then given as follows:

Cancer of the Breast, a symposium by the American Society for the Control of Cancer, Dr. John H. Flude, western field representative. Discussion by Drs. C. G. Hilliard, J. A. Patterson, C. C. Owen, P. M. Savage, Sr., C. L. Emmons, and John C. Staub, Jr.

A. E. VARDEN, *Secretary.*

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on January 9.

The meeting was preceded by the customary supper meeting at the Hotel Wolf, called to order at 6:15 p. m., at which there were twenty-two in attendance. Dr. Sam Hanson presented a very interesting paper on *The Occurrence and Management of Persistent Occiput Posterior.*

The regular meeting was called to order at 8:15 p. m. by the retiring president, C. A. Broaddus.

The petition for membership of Dr. John Rosasco being favorably acted upon by the Admissions Committee, and there being no objections on the floor, he was elected to membership. The petitions for membership of Doctors Green, Hooker, Peterson, DenDulk, and Baron were read and referred to the Admissions Committee.

Dr. A. L. Van Meter reported on the status of the postgraduate study course, stating that the balance on hand in the treasury at the termination of the course could be used in 1936 possibly to bring some man from the East to present a series of talks. Dr. R. T. McGurk moved that the Society go on record thanking the membership of the Postgraduate Study Committee for their efforts in presenting the postgraduate course. This was seconded by Doctor English, and the motion carried. Doctor Fitzgerald moved that the secretary write a note of appreciation to all of the men who presented papers to the postgraduate study course. Carried. The certificates of completion of the postgraduate study course were then presented by President C. A. Broaddus.

The papers of the evening were presented by Dr. E. Butler, who spoke on *Aid to Diagnosis in Wounds in the Abdomen* and *Recent Advances in the Treatment of Poisons.* Both papers were very enthusiastically received and presented a wealth of information on the handling of emergency cases. The discussion was participated in by Doctors Chapman, McGurk, Powers, Griner, McNiel, H. Smythe, and Van Meter.

There being no further business to come before the Society the meeting was declared adjourned at 9:30 p. m. and refreshments were served.

G. H. ROHRBACHER, *Secretary.*

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SAN LUIS OBISPO COUNTY

At the annual meeting on December 28, 1935, the San Luis Obispo County Medical Society elected the following officers: L. T. Wade of San Luis Obispo, president; Charles Kennedy of Paso Robles, vice-president; F. W. Yocom of San Luis Obispo, secretary-treasurer; C. J. Teass of San Luis Obispo, delegate; D. A. Crew, alternate.

Board of Directors—F. C. Mugler, Ira Bartle, of San Luis Obispo, and A. H. Wilmar of Paso Robles.

The dues for the ensuing year were set at $15.

The above election followed the annual dinner at the Paso Robles Hotel. During the business meeting the Woman's Auxiliary to the San Luis Obispo County Medical Society held its annual meeting.

The following telegram was sent to Governor Merriam on January 3:

"The San Luis Obispo County Medical Society unanimously requests that you reappoint Dr. Charles B. Pinkham as a member of the State Board of Medical Examiners."

FRANK W. YOCOM, *Secretary.*

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SANTA BARBARA COUNTY

The annual banquet meeting of the Santa Barbara County Medical Society was held at the Hotel Mar Monte, Monday evening, January 13, President E. K. Shelton presiding. There were present seventy members and thirteen guests.

During the interval preceding the banquet, cocktails were served, and the tellers distributed and collected the ballots for the annual election.

During the dinner course the assembly was most enjoyably entertained by Dr. Henry Profant and his group with instrumental music and songs.

At the conclusion of the dinner the president announced the election of the following officers for the ensuing year: P. A. Gray, president; Irving Will, vice-president; H. G. Hanze and C. G. Baird, vice-presidents-at-large; W. H. Eaton, secretary-treasurer. Delegates to the State Association convention (two-year term), Hugh Freidell and Rodney Atsatt. Alternates, Richard Evans and H. E. Henderson. Council, Hugh Freidell, H. E. Henderson, and O. C. Jones.

After brief remarks by retiring President Shelton and incoming President Gray, the speaker of the evening, Dr. A. Th. Polyzoides of the University of Southern California was introduced. Doctor Polyzoides' subject, *The Rising Importance of the Pacific Area*, was discussed most ably and interestingly, and brought forth many facts of extreme importance regarding our future relations with the Orient. The discussion was most timely and greatly enjoyed by all.

Guests of the Society, Doctor Grimm of the dental society and Mr. Ross of the Bar Association, were then called upon for brief remarks.

Upon balloting, Dr. J. Kenneth Patterson was unanimously elected into the Society.

Dr. Charles Baird, representing the Santa Maria branch of the county society, extended an invitation that the May meeting of the Society be held in Santa Maria. The invitation was unanimously accepted.

W. H. EATON, *Secretary.*

SISKIYOU COUNTY

The regular meeting of the Siskiyou County Medical Society was held at the Yreka Inn at Yreka on December 15, 1935. The meeting was called to order by President J. R. U. Campbell.

A letter was read from the State Board of Medical Examiners stating that Doctor "Tinker," who has been practicing in the city of Mount Shasta without a license, had been warned to discontinue such practice under penalty of criminal prosecution.

A card was received stating that Doctor McCann, who was formerly at McCloud, had transferred to the Upper Mississippi Medical Society.

It was moved, seconded and passed, that a petition be sent from this society to Governor Merriam requesting that he reappoint Dr. Charles B. Pinkham as secretary of the State Board of Medical Examiners.

Moved, seconded and passed, that a letter of commendation be sent to Doctor Seeley (who has moved to Redding) for his untiring efforts as secretary-treasurer during the past year.

Election of officers was held and the following were elected to office: C. C. Dickinson of McCloud, president; Doctor McGuire of Mount Shasta, vice-president; E. F. Carlson of Fort Jones, secretary-treasurer.

A round-robbin discussion of interesting cases and their treatment was then carried out. The next meeting will be held at Mount Shasta City on January 26.

E. F. CARLSON, *Secretary.*

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SOLANO COUNTY

A regular meeting of the Solano County Medical Society was held Tuesday evening, January 14, at eight o'clock at the Casa de Vallejo Hotel.

After dinner, routine business was transacted.

Dr. M. Elizabeth Jenkins was elected to membership in the Society.

Dr. A. V. Doran of Vallejo introduced the guest speaker of the evening, Dr. Hans Lisser, clinical professor of medicine at the University of California. The title of Doctor Lisser's talk was *Adrenal Cortical Syndromes, with Mention of Cushing's Disease, and Arrhenoblastoma.* The subject was very interesting and greatly enjoyed by all the doctors present.

In addition to members of the Solano County Medical Society, guests from Mare Island, Crockett, Benicia, Napa, and from the Napa State Hospital were present.

JOHN W. GREEN, *Secretary.*

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SONOMA COUNTY

The Sonoma County Medical Society met on January 9 at the Occidental Hotel in Santa Rosa. Twenty-five members were present.

Dr. E. B. Shaw of San Francisco addressed the Society on *Communicable Diseases,* stressing recent ideas of prophylaxis. His paper was well received, and our members were impressed with the excellent presentation of a very interesting subject.

A short discussion concerning the care of the indigent sick was held during the evening.

CLIFFORD M. CARLSON, *Secretary.*

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STANISLAUS COUNTY

The regular monthly meeting of the Stanislaus County Medical Society was held at the Hotel Modesto on December 13, 1935, with thirty-two members present. A splendid dinner was served by the management of the hotel.

We had as our guests, Dr. Robert Peers, president of the State Medical Association; Dr. Frederick C. Warnshuis, secretary of the State Medical Association; and Dr. Axcel E. Anderson, district councilor.

Following the dinner a motion was made by Dr. Hans Hartman that, inasmuch as it was Doctor Peers' sixtieth birthday, the Society should extend to him some remembrance in honor of the occasion. Therefore, he moved that Doctor Peers be made an honorary member of the Stanislaus County Medical Society. The motion was seconded by Doctor Morris, and the secretary was instructed to cast a ballot for a unanimous election of Doctor Peers. Motion carried. The secretary announced Doctor Peers elected.

Application of Dr. Hoyt Gant for membership was presented. Moved by Doctor DeLappe, and seconded by Dr. Hans Hartman, that Doctor Gant be accepted to membership. Motion carried.

Doctor Maxwell gave a report regarding Mrs. King, public health nurse. . . .

There being no further business to come before the meeting, President Allen introduced Dr. Robert Peers. In opening his address, Doctor Peers said: "Fellow members of Stanislaus County—You have given me the most wonderful and acceptable birthday gift. I shall always remember and cherish your kindness and courtesy as well as the good fellowship that has already been expressed." Doctor Peers then spoke upon the work of the State Medical Association and dwelt upon the betterment of its present conditions. He reported thirty-nine societies representing 90 per cent of the eligible physicians and surgeons. These members elect the House of Delegates, which is the governing body; therefore, the House of Delegates represents 90 per cent of the physicians and surgeons of the State. He stressed the necessity of reading CALIFORNIA AND WESTERN MEDICINE, with special emphasis on the editorials, for there are to be found problems of organized medicine. In closing, he stated that each and every member having any problems to consider should feel free to consult the councilor of his district, for in this way the district becames a constructive unit of a cohesive State Association.

Dr. Axcel Anderson, councilor of this district, was the next speaker. Doctor Anderson spoke at some length on the report of the State Committee on County Hospital Problems. He also called to our attention the present and ever-increasing problems of aid to superannuated physicians, saying that he believed this problem was becoming more and more a vital one, and asked that this society and all others give it earnest consideration.

Doctor Warnshuis was next introduced. He first paid tribute to Doctor DeLappe, retired councilor of this district, for his long sincere services to the medical profession of this State. Doctor Warnshuis spoke at length on the progress of medicine, stating that through postgraduate work only could the modern physician keep abreast of the times. Medical society meetings are of the most extreme importance, and the present proposed extension course should be of great value to all of the medical profession. He next touched upon liability malpractice insurance. He stated that one of the companies would increase its rates 20 per cent on January 1, 1936, and that there has been a 300 per cent increase in the rates of this type of insurance in Los Angeles County. Also that the State of California is paying 50 per cent higher rates than our brethern on the eastern seaboard. There should be a report early in January by the State committee investigating this problem, with the idea in mind of supplying through the State Association, malpractice liability at cost to its members. Doctor Warnshuis advised all members to avail themselves of the present legal protection that the State Society now furnishes.

Doctor McPheeters expressed his appreciation of the above service and stated that this legal protection had saved him a great deal of worry and costs.

The Stanislaus County Medical Society, through its president, expressed to all the speakers its appreciation of their time and individual effort that they had so gladly and gratuitously given.

E. F. HAGEDORN, *Secretary.*

TULARE COUNTY
KINGS COUNTY
(Joint Meeting)

The final 1935 meeting of the Tulare County Medical Society was held at Motley's Café, Visalia, at 6:30 p. m. on December 22, 1935. Dinner preceded the meeting.

The Kings County Medical Society met with us by invitation to hear the reports of the State Society officers, who were our guests on this evening. President Ray Rosson presided. President Chamlee of the Kings County Medical Society responded for the visitors. The meeting was then turned over to the State officers, who were the guests of honor.

Robert Peers, president of the State Medical Association, reported on his plans of visiting every county society in the State and discussed the workings of the State Association.

District Councilor A. E. Anderson of Fresno outlined the county hospital survey program and submitted a preliminary report of the work done.

Dr. F. S. Warnshuis, state secretary, spoke of the State Association's activities in regard to: (*a*) Postgraduate conferences. (*b*) Program of educating the public on medical problems through corps of speakers for various public groups. (*c*) Recent developments on hospital insurance, and increased premiums for malpractice insurance; and urged us all to read the official publication of the California Medical Association, to keep abreast of problems of organized medicine in California.

Dr. LeRoy Briggs, professor of clinical medicine at the University of California Hospital, delivered the scientific paper of the evening. The *Clinical Significance of Jaundice as a Symptom* formed the subject of his paper, which was most ably presented. A rising vote of appreciation was extended Doctor Briggs for his talk and willingness to answer the many questions at its conclusion.

At the close of the clinical program a regular business session took place. Various communications were read. A motion was made by Doctor Lipson to urge the reappointment of Dr. Charles B. Pinkham to the State Board of Medical Examiners, and instructions given to forward a copy of this resolution to Governor Merriam. The motion was seconded and carried.

A motion by Doctor Ginsburg was carried to reinstate Doctor Zeller.

Nomination and election of officers for 1936 was next in order, and resulted as follows: J. C. McClure of Lindsay, president; John Fillmore of Strathmore, vice-president; K. F. Weiss of Visalia, secretary-treasurer. Censors, Doctors Tourtillott (1937), Ginsburg (1938), Ray Rosson (1939). Delegate, Ray Rosson of Tulare. Alternate, K. F. Weiss of Visalia.

Dues for the year 1936 were voted to be left as formerly—$10, California Medical Association; and $10, county society.

An unusually large attendance marked this meeting. Members and guests present included Doctors Gronemiller, Murphy, Bridgman, Chamlee, Fillmore, Tourtillott, Nicholson, A. Miller, Preston, Newbecker, P. Miller, Hellbaum, Brigham, Watke, Matthias, Crawshaw, Charles Rosson, Winns, Falk, Neal, Lipson, A. E. Anderson, Robert Peers, Ray Rosson, F. C. Warnshuis, Weiss, LeRoy Briggs, Ginsburg, E. C. Bond, Guido, McClure, Betts, and Parkinson.

Doctor Rosson then closed his 1935 term of office by thanking the members for their support during the year.

KARL F. WEISS, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (17)

Alameda County.—Emery R. Ranker, Thomas Hubert Reiss.

Napa County.—Frank X. McGreane.

San Bernardino County.—Justin W. Neighbor, Marvin K. Paup.

San Diego County.—J. Aston Jetton, James R. Matson, Horace G. Merrill, Rufus A. Schneiders, John W. Warren.

San Joaquin County.—J. L. Rosasco.

San Luis Obispo County.—Justin A. Frank.

Santa Clara County.—Thomas H. Boone, Howard George Diesner.

Solano County.—Herman B. Perkins.

Stanislaus County.—Hoyt R. Gant.

Tulare County.—Harry Falk.

Transferred (3)

Peter Paul Baron, from Siskiyou County to Alameda County.

Orta Edward Kuhn, from Napa County to San Joaquin County.

Leslie D. Trott, from Los Angeles County to Orange County.

Resigned (4)

J. W. Calkins, from Alameda County.

Edmond W. Parsons, from San Francisco County.

H. Schwartzman, from Alameda County.

Reuben S. Zumwalt, from San Francisco County.

In Memoriam

Dubois, Charles Warren. Died at Los Angeles, December 17, 1935, age 33. Graduate of Cornell University Medical College, Ithaca, New York, 1927. Licensed in California in 1930. Doctor DuBois was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Graham, John Alexander. Died at Los Angeles, January 2, 1936, age 59. Graduate of the Chicago College of Medicine and Surgery, 1915. Licensed in California in 1923. Doctor Graham was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Rathbun, William T. Died at Colusa, December 28, 1935, age 66. Graduate of the University of California Medical School, San Francisco, 1892. Licensed in California in 1893. Doctor Rathbun was a member of the Yolo-Colusa-Glenn County Medical Society, the California Medical Association, and the American Medical Association.

✝

Wheeler, Ira Abbey. Died at St. Helena, January 2, 1936, age 75. Graduate of the California Eclectic Medical College in 1894, and licensed in California the same year. Doctor Wheeler was a member of the Sonoma County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Wishful Thinking

In seeking solution for confronting problems in government, legislation business and social activities, satisfactory plans for reform are delayed because of a very wide tendency toward wishful thinking on the part of all peoples. There is much talk and harangue, but very little thinking. And among those who have attempted to think the nature of thought follows wishful lines. A wish is expressed and advanced as a solution, but right there the effort ends. Wishes will never bring about solution. Effort must be recorded.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

Basic interests are common and action must be revealed ere the eleventh hour has struck. Petty differences must be put aside. United organized effort must be made to gather up the dragging reins of government business and social security and to take our place in the driver's seat.

Protests against "crackpot" social and economic legislation: denunciation of irresponsible legislators and unscrupulous public officials and politicians is useless unless it results in united action, and action will not be enlisted till the wishful thinker becomes a positive thinker. Impelled by a positive purpose, united, then by action society can rid itself of evil things, business can go on its way to prosperous days, and government will be directed and administered by citizens that are capable, competent, efficient and honest.

Local, state, and national elections are near at hand. Candidates for many elective offices are being groomed and assuming positions in the election race. Politicians are building their fences and planning for the spoils. Mr. Voter is only wishfully thinking when positive action is needed.

Our 5,400 members can exert a wholesome influence upon more than three-quarters of a million voters and cause them to become positive thinkers united to become positive workers for reform in all avenues of life. More will be said about this later.

Just now the urge is that you assume a positive rôle prepared to enlist for united action. Decline to pledge support for any candidate until you have been reliably informed as to his capability, integrity, and stand upon the questions of the day. At an early date you will be enlightened as to certain positive movements that will bring relief from present intolerable conditions and your active support will be solicited.

* * *

Expert Testimony

One does not have to go far to secure evidence that under legal procedure personal injury cases are not settled by a dispassionate jury inquiring into facts. It is evident that these cases are "built up" to maximum effectiveness. We are all more or less informed as to how expert testimony is introduced and how it is given consideration by a jury. It can be stated, as did a lawyer addressing the law class in Harvard, that "the present mode of procedure, in so far as medical testimony is concerned, is not a particularly edifying one." In place of reforms in court procedure in personal injury cases the situation is becoming more and more intolerable.

Now come F. E. Elliott and Ramsay Spillman, who advance a method and plan to correct this miscarriage of equity and justice. In the October, 1935, issue of the law journal—*Law and Contemporary Problems*—they cite many abuses and review the whole subject. They conclude with these recommendations!

1. Case to be heard by a tribunal of three—one judge, a medical man, one layman.
2. Eliminate present contingent fees of the attorney. Let the court determine the value of an attorney's services.
3. Impose a penalty upon an attorney who brings an action for which there are no reasonable grounds.
4. Develop standards for use in determining degree and consequences of personal injury.
5. Limit medical testimony to fundamental facts.
6. Experts are to be employed by the court and become servants of the court in expressing opinions.
7. Experts can only be questioned by the court.

As they are discussed these proposals create a strong appeal and a desire to bring about their initiation in a problem that calls for reform. To that end members are invited to send in their comments. If sufficient interest is manifested the Committee on Public Relations will then undertake to see how this reform may be accomplished in the courts of California. Please send us your reactions and comments.

* * *

Important "Dont's"

If members will learn to observe the following advice they will save themselves from much trouble:

1. Don't assign accounts to a collection agency until you ascertain the standing and reputation of the agency. This department will be glad to inform you.
2. Don't fall for "directories" that promise you business if you will pay a certain sum for listing your name.
3. Don't take out an insurance policy because you are given a promise of appointment as a medical examiner or member of their panel of physicians.
4. Don't operate on a minor without written consent of the parent or guardian.
5. Don't perform a sterilization operation on a minor without a *court order*. On those who have attained their majority, secure written consent.
6. Don't operate on anyone without a clear and full understanding as to the nature of the operation. See *The Journal of the American Medical Association*, p. 33, January 4, 1936, issue for forms for consent for operations, examinations, and autopsy.
7. Don't sue for an account till the period of limitations has expired.
8. Don't report on services rendered to life insurance companies without patient's consent. Obtain fee for these reports from the company.
9. Don't make affidavits until you know their purpose.
10. Don't fail to obtain consultation or advice when you are in doubt.
11. Don't employ lay technical x-ray and laboratory persons. Use licensed physician's laboratories.
12. Don't violate patients' confidential physician-patient relationship.
13. Don't fail to keep complete accurate records.
14. Don't be an easy mark in falling for agents' representations.
15. Don't sign till you know what you are signing.
16. Don't fail to consult your investment banker before investing in any business or promotion scheme.
17. Don't prescribe narcotics for transient persons.
18. Don't sign a death certificate if you have not seen the patient within thirty-six hours before death. Call the coroner.
19. Don't neglect carrying indemnity defense insurance.
20. Don't break the Golden Rule.

* * *

Conference with Chiefs of Medical Staffs of Hospitals

On January 18 the Committee on Public Relations held a conference with representatives of hospital medical staffs. The purpose of the conference was to accomplish the formulation and acceptance of a state-wide policy in regard to what shall be incorporated in "hospital service" in any plan of hospital insurance authorized under Assembly Bill 246, passed by the last legislature.

Some fifty representatives attended. Profitable discussions and suggestions ensued in the two-hour session. The conference concluded with the appointment of three representatives of the hospitals and of the laboratory directors who will meet at an early date with the Committee on Public Relations for the purpose of drafting a state-wide policy. When this is accomplished, due announcement will be made.

* * *

Minutes of the Meeting of the Committee on Public Relations, January 18, 1936: Conference with Hospital Representatives

Representatives of the Class A hospitals throughout the State of California met with the members of the Committee on Public Relations on January 18, 1936, at the Sir Francis Drake Hotel, San Francisco.

The meeting was called to order by Chairman Dukes at 4:15 p. m.

Doctor Dukes greeted the visiting staff members.

Doctor Warnshuis gave an outline of the features of an insurance plan which would meet with the approval of the Department of Public Relations of the California Medical Association. These features are as follows:

1. The patient should have free choice of hospitals.
2. The patient should have free choice of doctors, but he must be a reputable approved physician.
3. Services given the patient should consist only of the ordinary hospital care—not to include services of laboratory technicians, as it has been held that services of pathology and x-ray laboratories should not be a part of the hospital service.

Doctor Warnshuis asked that the various hospitals submit their plans for hospital insurance to their own county society and they in turn will submit the same to the Committee on Public Relations, which will be glad to render any advice or counsel desired.

Doctor Dukes called on Dr. Harold Brunn to outline his views for hospital insurance. Doctor Brunn stated that the hospitals are grouping together to formulate a plan, and all of the hospitals in San Francisco have joined the group, with the exception of the University of California (due to State affiliation) and Mary's Help Hospital, which will probably join at a later date.

The plan set forth by Doctor Brunn was as follows:

The patient is entitled to have any doctor he wishes. The doctor will render a bill to the hospital for laboratory services. The patient will be entitled to any service which the hospital now gives, including services of the x-ray laboratory.

It is Doctor Brunn's contention that the radiologist and roentgenologist would have a better chance of changing the present order of their standing under the hospital insurance plan than they have at present.

Dr. Loren Chandler of San Francisco said the hospital group spoken of by Doctor Brunn is composed of three representatives from each hospital, having an executive committee of six. An agreement of policy between the nonprofit organization and the patient and between each hospital and nonprofit organization has been drawn up. When the final copy has been compiled, it will be submitted to a group having a radiologist representation. This policy will be offered to employed groups only at probably 80 cents per month to each individual. This policy will not include the dependents of the employed group. Hospital services will be given for a limit of twenty-one days in any year. Services to consist of bed, board, general nursing care, ordinary drugs, etc., and the services of a physician who is a member of the hospital staff. The patient will be entitled to select any hospital in the group and must be admitted by his own physician. The facilities of the operating room will be given the attending physician and the facilities of the x-ray room and laboratories to be used by any radiologist that is acceptable to the hospital. This policy will be submitted to the various members of the groups and in its final form to the Council of the California Medical Association.

Dr. E. J. Best, representing the Franklin Hospital, stated that the Franklin Hospital has not yet agreed to join the hospital organization, as the constitution by which the hospital is now operated will not allow such action, but the staff members are entirely in accord with the movement. He stated that the hospital would perhaps join at a later date.

The Sutter Hospital of Sacramento was asked to send a representative to the meeting, but were unable to do so. Doctor Warnshuis read a letter from Doctor Scatena, chief of staff of the Sutter Hospital.

Dr. Haight Mitchell of Alameda said he thought a hospital service plan should be worked out which did not include radiologists, pathologists, roentgenologists, etc., and, although a plan could not be worked out which would be workable in every city, the policies issued should be as uniform as possible.

Dr. Clain Gelston of the Children's Hospital set forth a plan by which the hospital will not give medical services, but will offer to the physician the use of the hospital equipment. The patient to be brought in by his own physician. The x-ray department, including the technicians, will be at the disposal of the physician.

Doctor Cook of Los Angeles spoke of a plan which has been in operation in Los Angeles and which has worked out most satisfactorily. He will send a written copy of the plan.

Dr. Raymond Swinney of Long Beach urged that a working plan for hospital insurance be inaugurated as soon as possible or the medical profession will be forced to accept a plan not satisfactory to them.

Dr. Lowell S. Goin of Los Angeles spoke of the position of the roentgenologist in medicine of today and asked that these men be given consideration in the forming of the hospital insurance plan. He urged that in the forming of the plan the hospitals should not be given the right to practice radiology.

Dr. Alexander Keenan of San Francisco: The hospitals are not practicing medicine; the facilities are there for the use of the physician. The physician should send his own bill to the hospital. The hospital will be paid $6 a day from the central fund. When any special work is done by the technician, the technician will be paid for his services. The x-ray man is now paid by the hospital, but if this arrangement is not satisfactory he can send his bill direct.

William Holley of Los Angeles is entirely in agreement with the hospital insurance plan and believes such a plan should be made to meet the requirements of the middle class of people. Doctor Holley also spoke of the necessity of the medical profession's grouping together.

Dr. T. Henshaw Kelly does not believe the hospital should give any service other than that of bed, board, and general nursing care. The doctors and hospitals should coöperate with each other to make a hospital insurance plan workable. The pathologists and roentgenologists are medical doctors and should be treated as such; they should not be a separate part of the medical profession.

Doctor Dukes stated that, from hearing the various discussions, a working plan could be formulated and asked that the various groups send in their reactions to the questions brought up in this meeting.

Dr. Rodney Yoell spoke of the obligation of a physician to his patient and the responsibility of the doctor for this patient. He said the technical men should work out their own problem in regard to who should and should not practice pathology, roentgenology, etc., and how the bills of these men should be rendered—to the physician in charge or to the patient direct.

Doctor Stone: The radiologists are not trying to change the present plan of practice of medicine, but are working toward the recognition of the profession that x-ray work is specialty work.

Dr. Morton Gibbons: It is suggested that a meeting of the Public Relations Committee with three representatives of hospital and roentgenologists be arranged. This was concurred in, and Doctor Warnshuis will notify the members when the meeting is to be held.

After the adjournment of the meeting of the staff members and the Public Relations Committee, the regular meeting of the Public Relations Committee was called to order by Chairman Dukes.

Doctor Warnshuis outlined a plan whereby the material of the Public Health Institutes will be sent to the San Diego Fair. The California Medical Association has been granted 22,000 feet of space for these exhibits. In addition, the American Medical Association will also have space for exhibits at the fair. If the public health exhibits are sent to the Fair, the Public Health Institutes to be held in various parts of the State will be suspended until after the month of September, 1936. It was moved by Doctor Peers, seconded by Doctor Gibbons, that the exhibits be sent to the San Diego Fair. Carried.

The Federation of Women's Clubs are desirous of putting on an educational program throughout the State on the mental hygiene problem of the child and the adult. They have requested that the Department of Public Relations of the California Medical Association coöperate with them in this work.

It was moved by Doctor Gibbons and seconded by Doctor Dukes that the Department of Public Relations coöperate with the Federation of Women's Clubs in this work. Carried.

Doctor Warnshuis suggested that at the next annual meeting of the California Medical Association to be held in Coronado in May that the Association sponsor an evening public meeting in San Diego.

It was moved by Doctor Gibbons and seconded by Doctor Askey that this meeting be arranged. Carried.

Doctor Warnshuis displayed the placard which has been prepared to hang in the reception room of doctors' offices, entitled "The Physician and His Patient." It was suggested that these placards be sent with certificates to all doctors. It was moved by Doctor Gibbons and seconded by Doctor Peers that these placards be sent to the members. Carried.

The activities of the Public Relations Department were outlined by Doctor Warnshuis. These activities include

the sending of press releases to some 250 newspapers every week. Several doctors have been asked to send in articles suitable for press releases. Doctor Warnshuis requested Doctor Askey to secure from Mr. Cochems some of his radio talks to be used as a press release.

Steps should be taken to contact the San Francisco Fair Administration members so that the California Medical Association may acquire directorships of the San Francisco Fair of 1938.

It was moved by Doctor Gibbons and seconded by Doctor Askey that steps be taken by the director to contact the San Francisco Fair Committee. Carried.

It was moved by Doctor Peers and seconded by Doctor Graves that the cost of printed placards for insertion with the monthly statements of public utility companies, etc., be ascertained. Carried.

Upon motion of Doctor Gibbons, seconded by Doctor Askey, Doctor Warnshuis was instructed to make arrangements for a future meeting of the chiefs of staff of the various hospitals throughout the State with the members of the Public Relations Committee. Doctor Warnshuis is to arrange the meeting and the time thereof.

Adjourned 6:45 p. m.

C. A. DUKES, *Chairman*,
F. C. WARNSHUIS, *Secretary*.

THE WOMEN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. THOMAS J. CLARK .....President
MRS. ELMER BELT.....Editor and Chairman of Publicity

State Auxiliary News

State Board Meeting.—A meeting of the officers and members of the board of the Woman's Auxiliary to the California Medical Association has been called by the president, Mrs. Thomas J. Clark of Oakland, for Monday, February 10, to be held in Los Angeles. All members of the state board are urged to attend, and all county presidents are most cordially invited to the session. The report of the convention chairman, Mrs. Elliott G. Colby of San Diego, of the preparations and plans for the annual state meeting to be held in Coronado the latter part of May will be of great interest to all Auxiliary members. The capable manner in which Mrs. Colby has handled the preconvention arrangements promises an excellent session. The details of the place and hour of the board meeting will be mailed by the state secretary, Mrs. C. Kelly Canelo of San Jose.

* * *

Fresno County to Have Auxiliary.—The Fresno County Medical Society held its annual meeting on December 3 at the University Sequoia Club, and invited as its guests the members' wives. Mrs. William H. Sargent of Oakland, State Chairman of Membership and Organization, was a guest of honor for the occasion, and in an after-dinner talk told of the need and the value of the medical auxiliaries organized throughout the State and the nation. Mrs. Sargent speaks well and to the point, and easily brought the already evident interest and enthusiasm of the Fresno women to decisive action. When the dinner program was over the women adjourned to a session of their own, and the initial plans of organization were formed. Officers of the new unit will soon be announced. The California Auxiliary gives warm welcome to this new county group, which becomes the seventeenth Auxiliary of the State.

† As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

Current Medical Topics Material.—In a recent "National News Letter," Mrs. Rogers N. Herbert of Nashville, Tennesse, National Auxiliary president, gives some of the sources from which materials and information on current medical questions can be obtained. These suggestions may prove helpful for study or programs in the county auxiliaries here. Mrs. Herbert says:

"Pamphlets and handbooks containing scientific information on nearly every subject which your Auxiliary might care to present may be secured at a nominal cost from Dr. W. W. Bauer, director of the Bureau of Public Instruction, American Medical Association, 535 North Dearborn Street, Chicago, Illinois. An especial need is felt at this time for pamphlets prepared by the American Medical Association on current subjects, such as 'New Forms of Medical Practice,' and the 'Handbook of Sickness Insurance, State Medicine, and the Cost of Medical Care.' These pamphlets may be obtained from the secretary of the California Medical Association.

"Special radio talks have been prepared by the American Medical Association for five, ten, and fifteen-minute broadcasts, and may be obtained for local use by writing the Bureau of Public Instruction. If planning local broadcasts, bear in mind the dates of the national American Medical Association radio programs to avoid conflicts. The American Medical Association began its radio broadcasts on October 1, to continue every Tuesday thereafter over the blue network of the National Broadcasting Company at 5 p. m., eastern standard time (2 p. m. Pacific time).

"The general theme, 'Medical Emergencies and How They Are Met,' will be presented in dramatized form with incidental music. Publicize these programs as widely as possible by announcing them in your various club activities and by telling the hour of the programs to all with whom you come in contact."

* * *

Suggestions from the National President.—In carrying on the work of the basic Auxiliary organizations, Mrs. Herbert, the National president, makes the following suggestions: "As we begin the records of the new year, let us continue to emphasize the importance of accuracy. It is vital to the National Auxiliary that each state and county organization keep their records accurate and up to date, with names and addresses in alphabetical order. The National treasurer and Chairman of Finance are working out plans to simplify the present system, and these plans cannot succeed unless based on accurate records of each individual Auxiliary.

"The National Auxiliary is dependent for its functioning power upon the coöperation of the state and county members, and their records may be compared with the wheels within a watch that, no matter how small, contribute to the perfect recording of time if perfect themselves, but throw the whole out of balance if imperfect.

"Records for permanent filing are sent to the historian by National, State, and County Auxiliaries, and from the historian they pass on to the Chairman of Archives.

"As we enter the new year, let us bear in mind the significant part that each Auxiliary member plays in forwarding our great health work, and let us remember that it is only through the closest coöperation and constancy to purpose that we can hope to achieve any measure of success."

* * *

County Auxiliary Reports

Kern County.—The Woman's Auxiliary to the Kern County Medical Society entertained their husbands at dinner on December 21 at the Stockdale Country Club. The tables were beautifully decorated with holly and red candles. This Christmas party is an annual occasion, and the attendance this year numbered over a hundred members and visitors. The guests of honor were: Dr. Robert Peers, president of the California Medical Association; Dr. Edward Pallette, the president-elect; Dr. C. G. Toland, the past president; Dr. Frederick C. Warnshuis, the secretary-treasurer; Dr. Henry J. Ullmann, a councilor of the third district from Santa Barbara; Dr. Charles Evans and Dr. and Mrs. Earl Moody, also of

Santa Barbara; Dr. John V. Barrow of Los Angeles and Mrs. Barrow, president of the Los Angeles County Woman's Auxiliary; Dr. A. E. Anderson, Mr. Alfred Siemon, and Mr. and Mrs. Dale Parke of Los Angeles. Some very interesting and instructive talks were made by the distinguished guests, after which the evening was spent in dancing and games.

The committee in charge of the arrangements included: Mesdames Louis Packard, S. C. Compton, P. N. Root, F. J. Gundry, Jack M. Nicholson, and N. N. Brown.

The next meeting of the Auxiliary will be held in February, when the State Auxiliary president, Mrs. Thomas J. Clark of Oakland, will be entertained.

MRS. N. N. BROWN, *President.*

* * *

Los Angeles County.—A Christmas party, together with gifts and a one-act play, featured the December meeting of the Los Angeles County Woman's Auxiliary, held in the Association building on the 17th. Gifts of food, clothing, and toys, brought to the meeting by the members, were later packed into baskets and distributed the day before Christmas to fifty families of the profession, who were incapacitated either by age or illness.

"The Doctor's Christmas Dinner," a play written by Mrs. Mark Albert Glaser, was put on by a spirited cast under the competent direction of Mrs. Charles E. Futch. This comedy represented a familiar scene in every doctor's household—the impatient family gathered about the table for a delayed dinner party. When the doctor does finally appear and a happy occasion is in sight, the inevitable emergency call comes and the doctor, like an old fire-horse keen for the fray, speeds off on his errand of mercy. The members of the cast included: Mesdames William R. Molony, Jr., Walter H. Boyd, Elizabeth G. McKelvey, E. B. Plimpton, A. Brockway, Dr. Silas A. Lewis, and Mr. Frank Tote.

Not included in the script of the play, came a near tragedy when Dr. Silas Lewis, impersonating the head of the house, flourished his carving knife realistically over the beautifully browned turkey, which his audience knew was to be raffled off later and, therefore, to be kept intact. Of this, the doctor's able acting seemed to give no hint, and the contour of the fine bird remained in jeopardy until the phone call rushed the carver from the scene to save a patient. The turkey raffle brought in proceeds of $25, which were used in helping to provision the Christmas baskets.

Mrs. Steele F. Stewart concluded the program with an excellent review of Hans Zinsser's colorful book, "Rats, Lice, and History." As the Lilliputians conquered Gulliver, so has the infinitesimal louse conquered great armies and changed the history of the world by spreading disease and destruction. Only since the life history of this insect has been studied and revealed by scientific workers has man become in part a conqueror, and only by constant and adequate vigilance can he remain in the ascendancy. This book presents a challenge to the world and a triumph for scientific research.

MRS. HAROLD E. CROWE, *Corresponding Secretary.*

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Sacramento County.—The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of the president, Mrs. Frederick N. Scatena, on Tuesday evening, December 17, 1935. There was no business meeting, as the occasion was planned as a Christmas party. Each member brought a "white elephant" gift, which was placed in a large basket in the entrance hall. Everyone played bridge and visited in the rooms, which were beautifully decorated for the holiday season. The president presented her Executive Board as hostesses for the evening.

The program chairman, Mrs. Harry Kanner, introduced Mrs. Irma Sheean and Mr. Rudolph Caffan, who sang, both as soloists and in duets, accompanied by Mrs. Zue Geery Pease. After the entertainment and cards, Mrs. E. O. Brown acted as Santa Claus and distributed the gifts. Light refreshments followed, served by Mesdames Scatena, Harry Kanner, A. K. Dunlap, William Van Den Berg, F. B. Brendel, T. Binkley, W. A. Reckers, J. T. Vance, E. O. Brown, Russel Harris, E. T. Rulison, Lorenz Ruddy, and George Foster.

SARAH L. BRENDEL, *Corresponding Secretary.*

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Santa Clara County.—The regular meeting of the Woman's Auxiliary to the Santa Clara County Medical Society was held on January 6 at Saren's in San Jose, with Mrs. Russel Lee presiding. Our guests, Mrs. Thomas J. Clark of Oakland and Mr. Louis Olsen of Palo Alto, spoke before the business session. Mrs. Clark told of the aims of the Auxiliary and of its growth. In her charming way she brought us in closer touch with the State and National Auxiliary organizations and with the work they are doing. Mr. Olsen, public health officer of Palo Alto, spoke on *Epidemiology.* He touched on the history, type and control of epidemic diseases such as plague, cholera, smallpox, typhoid, and typhus.

At the business meeting fifty members answered to the roll call. A paragraph from a letter from the Los Angeles County Woman's Auxiliary regarding the radio broadcasts was read. The program chairman announced that a party to include the husbands is being planned, and the exact date will be set in the near future.

MRS. MERLIN MAYNARD, *Corresponding Secretary.*

NEVADA STATE MEDICAL ASSOCIATION

R. O. SCHOFIELD, Boulder City.....President
C. E. SECOR, Elko.....President-Elect
HARRY W. SAWYER, Fallon.....First Vice-President
W. H. FROLICH, East Ely.....Second Vice-President
HORACE J. BROWN, Reno.....
.....Secretary-Treasurer and Associate Editor for Nevada

COMPONENT COUNTY MEDICAL SOCIETIES

CLARK COUNTY

The Clark County Medical Society held its monthly meeting on December 9, 1935, at the Sal Sagev Hotel. The following members were in attendance: Doctors Martin, Mildren, Balcom, Garrison, Van Meter, Jannson, Scofield, Slavin, Bryan, Blinstrub, McDaniels, and Woodbury. Guests of the Society were Doctors Schenck, De Smit and McKee, and Mr. Larson, x-ray technician of the Boulder City Hospital.

The Society was extremely fortunate in having for its guest and speaker of the evening, Dr. Ross Moore of Los Angeles. Doctor Moore has interested and acquainted himself with the field having to do with the autonomic system. The speaker, with the aid of charts, discussed the functions and the relationship of that system with the other systems and organs of the body. He was especially enthusiastic concerning research and experimental work under consideration, revealing the interrelationship of the autonomic system and the endocrine glands. It was his feeling that as additional knowledge is uncovered concerning the functions of the autonomic system, so will a much broader and more accurate insight into the field of therapeutics—both medical and surgical—be gained. Already progress has been made in the surgical treatment of those bugaboos of medicine, namely, arthritis and hypertension, through the resection of certain fibers of the autonomic system. The Society is deeply indebted to Doctor Moore for the pleasing and enthusiastic manner in which a rather technical subject was presented.

Following the address by Doctor Moore the Society proceeded with the election of officers. Dr. J. R. McDaniels, Jr., of Boulder City, was elected president; Doctor Scanlon of Searchlight, vice-president; and Doctor Slavin of Las Vegas was reëlected secretary-treasurer. New members elected to the Society included Doctors Schenck and De Smit of the Boulder City Hospital staff, and Doctor Bryan, who transferred from his Society in Mississippi to the local unit.

HALE B. SLAVIN, *Secretary.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American College of Physicians, Detroit, March 2-6, 1936. Mr. E. R. Loveland, 133 South Thirty-sixth Street, Philadelphia, Executive Secretary.

American Medical Association, Kansas City, Missouri, May 11-15, 1936. Olin West, M. D., 535 North Dearborn Street, Chicago, Illinois, Secretary.

Annual Congress on Medical Education, Medical Licensure and Hospitals, Chicago, February 17-18, 1936. Dr. W. D. Cutter, 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Coronado, May 25-28, 1936. Frederick C. Warnshuis, M. D., 450 Sutter Street, San Francisco, Secretary.

California Tuberculosis Association, Sacramento, April 2-4, 1936. Mr. W. F. Higby, 45 Second Street, San Francisco, Executive Secretary.

Medical Broadcasts*

The American Medical Association broadcasts over WEAF, the red network instead of the blue, as formerly, and certain additional stations of the National Broadcasting Company at 5 p. m., eastern standard time (4 p. m. central standard time, 3 p. m., mountain time, 2 p. m. Pacific time), each Tuesday, presenting a dramatized program with incidental music under the general theme of "Medical Emergencies and How They Are Met." The title of the program is "Your Health." The program is recognizable by a musical salutation through which the voice of the announcer offers a toast: "Ladies and Gentlemen, Your Health!" The theme of the program is repeated each week in the opening announcement, which informs the listener that the same medical knowledge and the same doctors that are mobilized for the meeting of grave medical emergencies are available in every community, day and night, for the promotion of the health of the people. Each program will include a brief talk dealing with the central theme of the individual broadcast.

Pacific Network.—The stations on the Pacific network are KGO KPO KFI KGW KOMO KHQ KFSD KTAR.

* * *

San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of February is as follows:

Tuesday, February 4—KYA, 6 p. m.
Tuesday, February 11—KYA, 6 p. m.
Tuesday, February 18—KYA, 6 p. m.
Tuesday, February 25—KYA, 6 p. m.

* * *

Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of February is as follows:

Saturday, February 1—KFI, 9 a. m. Subject: The Highway of Life.
Saturday, February 1—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, February 4—KECA, 11:15 a. m. Subject: The Highway of Life.
Saturday, February 8—KFI, 9 a. m. Subject: The Highway of Life.
Saturday, February 8—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, February 11—KECA, 11:15 a. m. Subject: The Highway of Life.
Saturday, February 15—KFI, 9 a. m. Subject: The Highway of Life.
Saturday, February 15—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, February 18—KECA, 11:15 a. m. Subject: The Highway of Life.
Saturday, February 22—KFI, 9 a. m. Subject: The Highway of Life.
Saturday, February 22—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, February 25—KECA, 11:15 a. m. Subject: The Highway of Life.
Saturday, February 29—KFI, 9 a. m. Subject: The Highway of Life.
Saturday, February 29—KFAC, 10:15 a. m. Subject: Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Mental Disease Is Discussed at Meeting of Dental Alumni.—Investigation into the causes of mental sickness involve two schools of research, the physiological and the psychological, according to a paper read by Dr. George S. Johnson, professor of neuropsychiatry in the Stanford University School of Medicine. The physiological school, he said, considers anatomy, neuropathology, chemistry, etc., in an effort to reach the source of the mental symptoms. The psychological school takes little or no account of any possible relationship between the mental processes or symptoms and changes in the brain.

The ancient conceptions that mental diseases were due to weird and mysterious agencies, the gods and devils of superstition, prevailed until comparatively recent times, when psychiatry began its beneficent ministrations, largely as a humanitarian movement. The early leaders in this movement help to establish the belief that those who were insane were sick, and thus cleared the path for intensive inquiry into the real nature and causation of mental disease.

Strange Action of Latent Infections Detailed in Paper.—The strange action of many latent or "symptomless" infections of both animals and humans were detailed at length in a paper prepared by Dr. Karl F. Meyer, director of the Hooper Foundation, University of California Medical School, for presentation to the annual meeting of the Society of American Bacteriologists in New York.

In the paper Doctor Meyer stated that a measles infection under the influence of convalescent serum may be modified to an unrecognizable condition, absence of fever or Koplik's spots, with an indefinite rise in temperature.

"Yet it is well known that these so-called 'mitigated forms' of measles are highly infectious and not infrequently the nodal centers for large epidemics."

The analysis of "silent or resting infection" introduced by surgeons during the war to characterize the delayed appearance of tetanus and gas gangrene infections, was touched on in the paper. According to investigations, spores of the tetanus bacillus may remain at the site of the inoculation in animal experimentation or may be carried to various parts of the body where they persist for long periods.

Certain infections introduced into the human body by traumatic injuries or gunshot wounds, especially shrapnel splinters, may remain within the wound or scar tissue without causing the least reaction. But they are a constant source of danger. An operation for the removal of shot fragments, performed weeks, months or years after the original injury, may lead either to a local or general tetanus or a rapidly fatal gas gangrene infection.

Sunday Pathology and Radiology Conferences at Coronado.—Sunday, May 24, 1936, the day before the California Medical Association annual session, will be devoted to the annual Cancer Commission conferences on radiology and pathology. Programs will be announced in later issues of CALIFORNIA AND WESTERN MEDICINE. Put the date on your calendar now.

Herzstein Lectures for 1936.—The Morris Herzstein course of medical lectures for 1936 will be given by Dr. John Gerald FitzGerald on March 2, 3, and 4. Doctor FitzGerald is professor of hygiene and preventive medicine, director of school of hygiene, director of the Connaught Laboratories, and dean of the faculty of medicine at the University of Toronto.

The titles of the lectures are:

March 2—Precept and Practice of Preventive Medicine.

March 3—The Practice of Preventive Medicine in the Prevention and Control of Diphtheria.

March 4—The Practice of Preventive Medicine in the Prevention of Localized Staphylococcic Infections.

The Morris Herzstein lectures were established in 1929 by the late Dr. Morris Herzstein of San Francisco, to be given under the direction of the medical schools of Stanford University and the University of California.

New Registration Law of California.—Registration laws enacted by the last legislature have made it necessary to postpone the securing of signatures for the Qualifying Certificate (Basic Science) initiative for two years. The following newspaper clipping gives information concerning registration dates:

"The presidential primary election in California on May 5 will have a vital bearing on the national election.

"You cannot vote in the presidential primary in California unless you re-register by March 26.

"The deadline is nearing.

"No matter when you registered previously, unless you have re-registered since January 1, you must register again."

National Health Council.—Health protection for the public of the United States is disposed of with the expenditure of only 50 cents annually per person in tax money, compared with the annual average expenditure of $4.52 per person for police protection and $3.32 per person for fire protection.

This is but one item in a pamphlet, "Health Facts," just off the press, published by the National Health Council, 50 West Fiftieth Street, New York City, as part of the material for the Health Today and Tomorrow campaign, recently launched and planned for the winter and spring months. . . .

We are graduating as many persons from the community into nervous and mental hospitals as we are sending out into the community each year from our colleges and universities. More than 50 per cent of all hospital cases in this country are those of some form of mental illness. The present annual average of mental cases recovered or improved is about 40 per cent.

Another statement: Relief funds make little appreciable addition to health services for the needy. Social Security Act appropriations, when they become available for public health work, will not be large enough to make up for the depression shrinkage in regular health department appropriations since 1929. . . .

Forty-eight per cent of the nurses available for community services are paid from private funds. On the other hand, the public health nursing service is the largest single item among public health expenditures—about one-third to one-half of the tax funds for public health goes to pay for public health nurses. Yet the total number of nurses now serving the country, however, amounts to only one-third of the number needed in communities. Public health nursing organizations have suffered a 10 per cent reduction in income, while the volume of free service has had to be increased.

Los Angeles County Medical Association: Membership Statistics.—The January "Bulletin" included the following interesting membership figures of the Los Angeles County Medical Association in the annual reports:

Membership in 1919	749
Membership in 1920	898
Membership in 1921	1,036
Membership in 1922	1,235
Membership in 1923	1,317
Membership in 1924	1,453
Membership in 1925	1,549
Membership in 1926	1,590
Membership in 1927	1,674
Membership in 1928	1,726
Membership in 1929	1,851
Membership in 1930	1,904
Membership in 1931	2,013
Membership in 1932	2,009
Membership in 1933	2,077
Membership in 1934	2,143
Membership in 1935	2,260

Reduced Mortality from Pneumonia.—Reduced mortality from pneumonia may be expected if plans of the Medical Society of the State of New York are successful.

A statement issued by Dr. Thomas F. Farmer of Syracuse, chairman of the Public Health and Medical Education Committee of the Society, states:

"Pneumonia kills about 12,000 persons in New York State every year. A considerable proportion of these persons suffer from types of the disease for which serum is available. The early use of serum in these cases will save many lives."

The development of the work is in direct charge of Dr. Russell L. Cecil of New York City, chairman of the pneumonia subcommittee. According to Doctor Cecil, the public should know that almost every case of pneumonia starts with a cold accompanied by fever. Early diagnosis is imperative for effective medical care.

Says Doctor Cecil in a statement issued by the medical society: "While serum is not available for all types of pneumonia, it is for some of the most prevalent forms. We hope to bring to the attention of the public the vital need for skilled nursing care. Generally, members of the household will not do. In no other disease does nursing care count for more in the battle the patient is making for his life. Nursing organizations are planning to extend nursing care for pneumonia patients. Too much must not be expected of the serum; it is a great help, it is true, but it will not supplant adequate medical and nursing care."

World Given Method to End Dentistry Pain.—The International News Service dispatch which follows promptly made for itself a place in the lay press and radio broadcasts:

New York, Jan. 22.—The dread of a dentist's drill was eliminated today when painless dentistry became a reality.

A secret formula of "anti-pain liquid" was disclosed by the discoverer, Dr. Leroy L. Hartman of Columbia University at a joint meeting of two New York district dental societies.

Doctor Hartman refused $250,000 for the formula, preferring to donate it "to humanity."

The discovery, climaxing twenty years of personal research, will enable dentists to make a tooth insensitive to pain during treatment, at a cost of less than one-half cent.

The application is simple. A pellet of cotton moistened with the solution is applied to the tooth. Drills may then be applied without pain to patients.

"This is my humble contribution to humanity, and I hope it will be the means of relieving much unnecessary pain," said the silver-haired discoverer.

Chemical firms today started preparation of the solution, which can be supplied in twenty-four hours.

The formula, by weight, follows:

Thymol, one and a quarter parts.

Ethyl alcohol, one part.

Sulphuric ether, two parts.

Dentists ranked the discovery with the demonstration of anesthesia in surgery in 1846.

Doctor Hartman spent eighteen years in research work before he found the formula.

Doctor Hartman said it had been tested in five hundred cases and proved thoroughly successful. A half-ounce bottle, costing less than $1, suffices for two hundred applications.

Los Angeles "Chinese Doctor" of Fifty Years Ago. The Los Angeles *Herald-Express* prints, daily, excerpts from its paper of fifty years ago. The issue of January 28, 1886, contained the following:

"Los Angeles has the novel sight, to many, of a Chinese doctor who drives in style to visit numerous white patients and administer his doses of whisky-soaked lizards. He goes dressed in the finest silks, drives a fine horse, sits in a costly buggy and is 'allee samee Melican doctor,' only he makes more money."

Radium Victim Gets French Honor Legion Cross.—International News Service prints:

"Paris, January 25.—Dr. Eugene Beaujard, famous French electroradiologist and victim of his own experiments with radium, has now lost his right hand and in return has been awarded the Cross of the Legion of Honor.

"Minister of Public Health Ernest Lafont went to Doctor Beaujard's bedside in Diaconesses Hospital here immediately after the operation and informed him that, in recognition of his sacrifices to science, the president of the republic had awarded him a decoration.

"The 62-year-old radiologist has already resumed work at the Bichat Hospital."

Mary's Help Hospital.—Dr. A. S. Musante, president of staff, has sent the following letter:

"*To the Editor:*—Relative to the resignation of Dr. Alfred C. Reed, mentioned in the January issue of your publication, I have been requested to advise you that Doctor Reed's resignation was accepted with a vote of thanks for his efficient work as head of the medical department of Mary's Help Hospital for the last eight years."

Hospital Council of Southern California: Bulletin on Special Nurses' Fees.—The Hospital Council of Southern California, over the signature of R. E. Heerman, secretary, 1414 South Hope Street, sent out in January the following announcement:

At the regular monthly meeting of your Executive Committee on January 9, 1936, the matter of increasing the special duty nursing rate from a basic $5 for eight hours to $6 for eight hours, as now being discussed by the California Nurses' Association, District 5, was brought to the attention of the members of the committee, and after a complete discussion of the matter they instructed me to issue this communication to you advising you of the following action:

It was recommended that we petition the nurses' organization to consider the matter of increased rates and discuss the situation with a committee from the Hospital Council. The committee members expressed themselves as being in sympathy with plans to increase compensation to special duty nurses, but did not feel that this was the opportune time, for the following reasons:

First: The public are still having difficulty in paying the full cost of hospitalization and always considers the special nurse's bill as part of the hospital bill.

Second: Most hospitals are still running deficits, and until the public are able to pay the full cost of hospitalization so that adequate increase in wages can be given to general duty nurses they do not feel that preference should be given to those doing special duty.

Third: Many doctors are protesting such increase, as it will prevent hospitalizing patients and, if hospitalized, will force such cases to be taken care of on general duty, thus increasing the cost to the hospital.

Fourth: Unless we can get the sympathetic understanding of the public, together with the doctors and hospitals, such increase in special nursing rates would tend to decrease hospitalization and calls for special nurses and throw an additional financial burden on hospitals, and at the same time decrease the possibility of doctors collecting any part of their fees.

This bulletin is issued in the spirit of coöperation, feeling that the best interests of the medical profession, hospitals, and nurses can be served by an understanding of these common problems and that hospitals should act as groups instead of individual units.

Ophthalmology Examinations.—The American Board of Ophthalmology announces that examinations for 1936 will be held in Kansas City, Missouri, on May 11, at the time of the meeting of the American Medical Association, and in New York City in October at the time of the meeting of the American Academy.

All applications for case reports must be filed at least sixty days before the date of examination.

Information, syllabuses, and application forms may be obtained from Dr. Thomas D. Allen, assistant secretary, 122 South Michigan Avenue, Chicago, Illinois.

Next Five Years to Be Made Safer Years in Auto Traffic.—Vehicide is to be made increasingly unpopular during the next *lustrum*, if plans of the National Safety Council eventuate successfully, for that organization has just announced a five-year, country-wide campaign to reduce motor-vehicle deaths at least 35 per cent by the end of 1940, looking toward the saving of at least 38,000 lives during the period. The drive started January 1, 1936.

It will be continued with growing intensity and momentum during the five-year period. It will be localized for each state and for virtually every city, where closest coöperation will be maintained with public officials, traffic safety leaders, safety groups, leaders in education, civic organizations, and interested individuals. It is planned to coördinate much of the existing safety effort, to centralize and standardize the work through application of tested methods proved by successful experience. Close coöperation with federal groups is assured.

The campaign, chiefly educational, will include a broad program of engineering and enforcement activities. The Council realizes that spasmodic safety drives have not yielded the desired permanent results. The serious nature of the problem demands a much broader program than has been attempted. Success will be sought by developing new ways of appealing to the individual motorist, to arouse a sense of responsibility and of good sportsmanship. A definite state-wide school program will be recommended for each state, together with the organization of state safety councils and localized organizations in municipalities.

Adoption of uniform laws, including standard drivers' license legislation, will be urged, with adequate administration of traffic laws, including state highway patrols. Standardization of accident reports also will be undertaken, as well as provision for more complete accident statistics, with their interpretation and application. Detailed engineering, enforcement and educational technique of the states and cities now doing outstanding work will be made available to the country at large, as one of the initial steps in the program.

The formal resolution, adopted unanimously by the Executive Committee at its November meeting, "pledges the Council's whole-hearted assistance and the active efforts of thousands of its members in all parts of the country, and invites the coöperation of all interested organizations and agencies to the end that during this five-year program at least 38,000 lives shall be saved and the killing and maiming of little children and all our people shall cease upon our highways."

The time is especially propitious. The 1935 toll of death and injury promises to approximate the tragic experience of 1934, when 36,000 persons were killed and a million and a quarter injured—of whom 150,000 will be crippled for the rest of their lives. The resolution declares that this situation "presents the most serious challenge to all who believe in a well-ordered society and the sanctity of human life."

Certain states and cities, through fine programs, have demonstrated through recent years that such an achievement is possible. Their experience shows that motor-vehicle tragedies can be not only controlled but actually reduced. Striking examples are the work of state-wide organizations in Minnesota, Massachusetts, and elsewhere. Twenty-three states have reported fewer deaths for the first nine months of 1935 than for the corresponding period of 1934; with Massachusetts reporting 14 per cent and Minnesota 11 per cent reduction. Many cities and villages,

through intelligent effort, have realized big reductions this year to date.

The Council has a huge functioning organization ready to proceed with increased vigor under the impetus of this larger and more intensive program. The fourth year of the National Traffic Safety Contest, now under way, shows that thirty-three states and more than eight hundred cities have entered into this worthwhile rivalry. The new and enlarged program should cause most of them to redouble their efforts.

LETTERS

Concerning an imaginary law demanding shock-proof x-ray rooms.

CALIFORNIA MEDICAL ASSOCIATION

January 31, 1936.

To the Editor:—A few days ago I received a communication from Doctor Yocum, secretary of the San Luis Obispo County Medical Society stating that an x-ray salesman inferred to him that the last legislature passed a law which requires the owners and operators of every x-ray machine to make them shock-proof, and in the event that they don't they would be subject to a fine or legal penalty. I had not heard of any such legislation and, consequently, I asked Mr. Peart to review the bills that were passed at the last legislature.

I enclose copy of reply received from Mr. Peart.

I think this is an item of sufficient importance to merit editorial comment, and suggest that you make such comment in order that our members be not imposed upon by manufacturers of electrical equipment.

Yours very sincerely,
F. C. WARNSHUIS, *Secretary.*

* * *

January 28, 1936.

F. W. Yocum, M. D.,
Secretary, San Luis Obispo County Medical Society,
San Luis Obispo, California.

Dear Doctor Yocum:

Doctor Warnshuis has referred to me your letter to him, dated January 23, 1936, in which you state that you are informed that there is a California law of recent enactment which will in the near future compel every user of x-ray equipment to have it completely shock-proofed.

A careful review of the laws passed at the last legislature does not show that such a bill was passed. There was one bill passed referring to x-rays which, however, I think would not refer to equipment. This bill did not become a law.

Inquiry here among some of the high-class x-ray distributors discloses that some salesmen are trying to high-pressure doctors with statements of the character made to you.

Trusting this gives you the information desired, I am

Very truly yours,
HARTLEY F. PEART.

Concerning the official Journal of the California Medical Association.*

New Bedford, Massachusetts,
January 25, 1936.

Dear Doctor Warnshuis:

Two days ago I received the January issue of CALIFORNIA AND WESTERN MEDICINE and have read, from cover to cover, every line. It is a splendid publication in every sense, and an example of what a state or regional journal should be. If I could afford it I would subscribe for and read it along with the journals of Pennsylvania, Texas, and Indiana. The last was most interesting in the days of Bulson's editorship. I believe that concentrating on these, with the inclusive reports of discussions of papers in the many district societies, would be more informing than hours of study of accepted standard textbooks. The medical matter is not subordinated to advertising, but prevails mightily throughout, is novel and most satisfying.

I noted the reprinting of the report of the Michigan delegates of the Atlantic City meeting of the American Medical Association on the press story of the "spanking." As I wrote you some time ago, I do believe that was a press gadget. I know nothing of the whole matter, as I heard no preliminary talk with or without malice of shifts in officers. As to Carl Moll, no one regretted more than I that he was not chosen as trustee. . . .

That we, of Massachusetts, should have been classed as "stand pat" Republicans added some mirth to our reading, as I am a Democrat, states rights variety at present seemingly rare, but I take it as a compliment. Mongan, "be-whiskered and good-natured" as he is, is our president and the one well-informed member on health insurance, and at present in the issues a bulwark of strength. . . .

With all kind regards,

Sincerely,
(Signed) EDMOND F. CODY.

ILLINOIS STATE MEDICAL SOCIETY
30 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS

January 27, 1936.

Dear Doctor Warnshuis:

Your communication of the 22nd received. I personally approve of it heartily and wonder why such a measure has not been introduced before.

I am sending it to our secretary, and it will come up at the March meeting of the Council. . . .

With best regards, I am

Cordially yours,
(Signed) CHARLES B. REED,
President.

Concerning expert medical testimony: A recent legal encounter.

On page 74 comment is made concerning a recent demand by certain attorneys to force a physician to give expert medical testimony without receiving a compensating fee. The subpoena served on the physician is printed below, followed by the opinion of the General Counsel of the California Medical Association, that code enactments by the last legislature have made no change in the established law, in so far as privileged and expert medical testimony are concerned.

* * *

SUBPOENA SERVED UPON THE PHYSICIAN

In the Superior Court of the State of California in and for the County of Los Angeles
No. 395035

Subpoena Duces Tecum to Appear Before a Notary Public

J. Edward Keating, Plaintiff, vs. The Pacific Mutual Life Insurance Company of California, a Corporation, Defendant.

The People of the State of California send greetings to John Ruddock.

We command you, that all and singular business and excuses laid aside, you attend and appear before C. R. Lilhestrom, a notary public in and for the County of Los Angeles, State of California, at the office of Mills, Hunter & Dunn, 1222 Chapman Building, 756 South Broadway, in the City of Los Angeles, County of Los Angeles, State of California, on Saturday, the fourteenth day of December, 1935, at 9 o'clock a. m. of said day, then and there to testify in this cause now pending in the above-named Superior Court, on the part of the plaintiff, and for failure to attend you will be deemed guilty of contempt of court and liable to pay all losses and damages sustained thereby to the parties aggrieved, and forfeit One Hundred Dollars in addition thereto.

And you are further commanded to bring with you and there produce the following-named books, documents and other things, to wit:

Records of the taking of an electrocardiograph of J. Edward Keating in June, 1935.

Notes made on the taking and reading of said electrocardiograph.

Electrocardiograph report dated June 19, 1935, or true copy thereof, made to the defendant or to Dr. Arthur E. Mark.

* See also Council Minutes (items 16 and 31, pages 123 and 124.

By order of the above-entitled Superior Court, this thirteenth day of December, 1935.

Attest: My hand and seal of said court, the day and year last above written.

(Seal) L. E. LAMPTON, *County Clerk.*
By K. E. LYNCH, *Deputy.*

* * *

OPINION OF COUNSEL PEART

December 27, 1935.

To the Secretary:—Answering your recent letter regarding amendment to the statute thought to impose an obligation upon physicians to give expert testimony without compensation. As I wrote you, the statutes have not yet been printed by the State printer, so we have to examine them painstakingly by advance sheets and without the aid of an index.

We find that the amendment in question is to Section 2021 of the Code of Civil Procedure providing for the taking of depositions of witnesses. Paragraph 1 of this Section now reads as follows, the words in italics have been added by the amendment of 1935:

"1. When the witness is a party to the action or proceeding or an officer, member, *agent, or employee* of a corporation, *or the agent or employee of a municipal corporation,* which *corporation or municipal corporation* is a party to the action or proceeding, *or an agent or employee of an individual who is a party to the action or proceeding,* or a person for whose immediate benefit the action or proceeding is prosecuted or defended."

This amendment does not affect a physician as an expert witness in any manner. It merely provides for the taking of the deposition of an agent or employee.

In the case of *Webb* v. *Lewald Coal Company,* the Supreme Court held that a physician who made a confidential report on a patient's condition, without treatment, could not be compelled to testify in regard to the patient's physical condition. This decision may be construed as determining that the relation of agency exists as between patient and physician.

You read me portions of the subpoena served on Dr. Ruddock, which, in our opinion, merely requires Dr. Ruddock to appear at a time and place specified and to give his deposition as to facts, and to produce the records specified.

The opposing attorney will doubtless very properly raise the question as to whether or not Dr. Ruddock is an agent or employee within the meaning of this Section. Before the amendment was adopted, Dr. Ruddock could be subpoenaed to attend the *trial* of this case and produce his records. Under the amendment, he may be subpoenaed to *give his deposition before the trial,* and that is all that the amendment does. This is based on the assumption that it will be held that Dr. Ruddock is an agent or an employee of some party to the action.

In our opinion, Dr. Ruddock can no more be compelled to give expert or opinion evidence without compensation at the taking of his deposition than he could be at the trial of the action.

The question of privilege also arises, and the patient's attorney, unless the privilege is waived, will doubtless object, if the testimony sought to be elicited from Dr. Ruddock is, in fact, privileged.

I trust that this will clarify the matter. I, of course, do not know the facts, or Dr. Ruddock's relation to the case, or who is calling him, whether his own patient or the opposing side; I do not have a copy of Dr. Ruddock's letter, mentioned by Dr. Kress.

As to opinion evidence, the amendment does not change the law at all. We wrote an extensive brief on this subject as *amicus curiae* in the above-mentioned case of *Webb v. Lewald Coal Company* (214 Cal. 182), copy of which is in your files. The Supreme Court did not pass on the question of compensation of a physician called as an expert. It holds that a physician may properly act for a patient without having thereby prescribed for or treated him, and the testimony of the physician may be privileged under subdivision 4 of Section 1881 of the Code of Civil Procedure, if he merely acts for the patient, even though the patient is deemed, when he brings an action for damages for personal injuries, to have consented to permit "any physician who has prescribed for or treated" him for such injuries to testify; and in such action, where patient had a neurologist examine her and make a report to aid her counsel in preparing for trial, but he did not "prescribe for or treat" her, his testimony was privileged.

I am endeavoring to locate a copy of this brief, and if I find it I will mail a copy to Dr. Ruddock.

I am sending copies of this letter to Dr. Ruddock and Dr. Kress.

Very truly yours,
HARTLEY F. PEART.

Concerning "vaccines" against anterior poliomyelitis.*

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
SACRAMENTO

December 19, 1935.

Dr. George Parrish,
Health Officer,
Los Angeles, California.

My dear Doctor Parrish:—We have just received a report from the Surgeon-General, United States Public Health Service, regarding poliomyelitis following vaccination against this disease. This article, prepared by Dr. J. P. Leake, Medical Director, United States Public Health Service, will appear in the *Journal of the American Medical Association* of December 28.

Inasmuch as three of the cases listed in his report occurred in California, I am recommending that the use of vaccination against poliomyelitis be discontinued in this state.

Very truly yours,
W. M. DICKIE, M.D.
Director of Public Health.

* * *

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

December 28, 1935.

To the Editor:—Doctor Geiger has instructed me to forward you the enclosed copy of Executive Order No. 119 that you may be informed of the attitude of the Director of Public Health on the use of immunizing agents against acute anterior poliomyelitis.

On authority from the Director of Public Health.

Sincerely,
JACQUES P. GRAY, M. D.,
Assistant Director of Public Health.

* * *

Executive Order Number 119

On the basis of the public announcement in the medical literature and in the press of the accumulated evidence against the use of so-called "vaccines" to protect the human against acute anterior poliomyelitis ("infantile paralysis"), by Medical Director J. P. Leake of the United States Public Health Service, and others, thereby confirming the recommendations made to the Director of Public Health by his Committee on Acute Anterior Poliomyelitis in the session of April 4, 1935, the use of such "vaccines" or other similar "immunizing" agents is prohibited within the city and county of San Francisco.

This action is believed indicated and appropriate as a public health measure directed at the control of a communicable disease, particularly because the evidence referred to supports the premise that acute anterior poliomyelitis occurs with a greater frequency in those "immunized" than in those not "immunized" in comparable population age groups under comparable conditions.

December 27, 1935.

Concerning privileged information: To whom may it be given:

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco,
January 15, 1936.

W. M. Dickie, M. D.,
Director of Public Health,
312 State Building,
San Francisco, California.

Dear Sir:—In your communication of the 8th instant you state that you are frequently called upon to furnish information contained in morbidity reports of cases of in-

*Article by Dr. J. P. Leake, reprinted from the *Journal of the American Medical Association,* December 28, 1935, appears on page 141.

fectious diseases. These reports, it appears, are submitted to your department pursuant to Section 297a of the Political Code and Section 16 of the Public Health Act, respectively.

You further state that you have for consideration two such requests at the present time, one being from the State Compensation Fund. The latter request is for the records of purported tuberculosis patients who are applying for compensation in "silicosis" proceedings. You ask whether such a state agency is entitled to these records of your department when such are needed for the performance of its duties.

In reply permit me to state that neither the State Compensation Fund nor any private agency is entitled to any information concerning individually named persons which is furnished to you under sections of the laws above referred to.

Section 2979 of the Political Code provides that the State Board of Public Health may publish statistics relative to numbers of cases of communicable diseases, and such further comparative statistics and information as may be deemed of value to scientists, the medical profession, the general public, and of aid in the maintenance of good health conditions. The Section is permissible only, subject to the limitations above noted, and contains no language which would indicate that the Board has authority to supply to anyone information concerning individuals.

Section 16 of the Public Health Act (Statutes 1907, p. 893, as amended) requires certain named persons, among them being physicians, to report the illness of any person of any infectious, contagious or communicable disease. It is required that this information be reported to the county, city and county, city, or other local health board or health officer, together with the name of the person, if known, and the place where such person is confined, and the nature of the disease, if known.

Section 11 of the Public Health Act requires county health officers, etc., to report in writing to the State Board of Health at certain specified times, information they have secured concerning infectious, contagious, and communicable diseases coming to the formers' knowledge. Section 13 subjects local health officers to the rules, regulations, and orders of the State Board of Health, or its secretary, and it is my understanding that reports concerning the diseases enumerated in such section are made pursuant to either regulations or orders of the State Board of Health, or its secretary, respectively, and under Section 2979a, which is the statutory counterpart of Section 16 of the Public Health Act.

A careful reading of the sections referred to fails to intimate that it is the duty of any health officer to supply information to members of any private or State agency. In fact, Section 2979a distinctly provides that official records of tuberculosis cases shall be for official use only and not open to public inspection. The latter portion of this section permits the State Board of Health, or its secretary, to take necessary measures to prevent the spread of such contagion, but this power is more commensurate with the right to quarantine than it is with the right to disclose information secured by either the State Board of Health or the Department of Public Health.

Reports furnished to you are not public records unless so declared by statute or unless, at least, a statute authorizes the publication of the matter therein contained. Section 2979 of the Political Code contemplates the publication of statistics only, and it has already been adjudicated in this State that not every record is public because of the fact it is filed with a public agency. (*Colnon* v. *Orr*, 71 Cal. 43.)

You are, therefore, advised that you are not required to furnish information contained in morbidity reports concerning individuals to any state or private agency, even though such reports relate to disease other than tuberculosis.

You also refer to the request of private agencies for names of persons afflicted with certain infectious diseases. These agencies, you point out, desire to solicit from such persons blood to be used in a serum for scientific purposes.

What has been hereinbefore stated is applicable to this situation as well. While it may well be that the furnishing of the names and addresses of these persons would be an advantage in the preparation of serums for use in the treatment of other diseases, the legislature has made no provision for the supplying of this information.

While Section 1881 of the Code of Civil Procedure does not deal with the subject of reports required by law to be made to the State Board of Public Health, it does state, "There are particular relations in which it is the policy of the law to encourage confidence and to preserve it inviolate"; and thereafter prohibits, except in certain stated instances, a licensed physician or surgeon from testifying in a civil action except with the consent of his patient. All such sections together would seem to indicate the intention of the legislature was to permit reports concerning individuals to be made to the State Board of Public Health for possible action by the Board or its secretary with respect to an individual case. Certainly the sections cannot be said to contemplate that any company or state agency might indirectly secure through the Board information which a physician is prohibited from disclosing except with the consent of his patient.

This does not mean that you could not advise private or public agencies the names of physicians handling certain types of cases (as for example, poliomyelitis), but it would seem to be incumbent upon such physicians to secure the consent of a patient before they could disclose to such agencies the patient's name. There would, likewise, seem to be power in the Board in proper instances to ascertain from the physician in attendance whether it might directly contact the patient to learn if the patient objected to giving blood for a serum either to the State or any public or private agency.

Very truly yours,

U. S. Webb, *Attorney-General.*
By Lionel Browne, *Deputy.*

Concerning proposed public health work under the Social Security Act.

State of California
Department of Public Health
Sacramento

January 16, 1936.

To the Members, State Board of Public Health:

Gentlemen:—Under the Social Security Act, if and when Congress appropriates the amount which has been recommended by the Administration, California's allotment for rural health and sanitation will be in the neighborhood of $200,000. These funds will be allocated by the United States Public Health Service.

The president of the Board, the director, and the regional consultant to the United States Public Health Service have had numerous conferences in reference to a program for the expenditure of these funds in the State of California. The carrying out of the program will place a great deal of additional work and supervision on this department. We feel that a bureau of county health supervision should be established, and a physician as chief of the bureau be selected who has had experience in the promotion of county health work, and who will act as administrative officer for the supervision of this work. It will be necessary to provide such personnel as secretary to the chief, stenographer, accountant, and supervising nurse.

It has been suggested by the United States Public Health Service that the Board consider the establishment of a bureau of industrial hygiene.

It has also been suggested that funds be set aside to pay for the inspection and control of psittacosis.

We have received a request from the United States Public Health Service that we take over the employment of eighteen rodent-control men, who have been with the Service for many years, and that their salaries be paid out of Social Security funds, which would amount to something like $20,000 a year. This, with the activities

outlined above in connection with the State Department of Public Health, would total about $50,000 annually.

The remainder of the funds that are allocated are to be used for strengthening of existing whole-time health departments in the way of adding additional sanitary inspectors and public-health nurses; organizing an additional four or five whole-time health departments in those counties which do not have such an organization, but have sufficient population to justify same. This would care for the major portion of the population of the State in some twenty-odd counties, leaving thirty-eight rural counties with small populations (from 250) to be divided into districts according to geographical lines. Each of these districts would have a whole-time health officer, sanitary inspectors, and public-health nurses living in the various community centers, who will act as representatives of the district health officer. There would also be a traveling unit, consisting of some of our present and additional personnel, to take care of emergencies that might arise.

This program probably could not be carried out during the first few years, but should be the ultimate goal, so that the whole State may have adequate public health service.

In addition to the foregoing, it is proposed that a school of public health be established on the Coast, to which the health officers of the western states will have the privilege of sending personnel to receive education in their particular field. This will be financed by other funds which will be expended in each state by the health officer for scholarships and maintenance expense of the candidates.

Very truly yours,

W. M. DICKIE, M. D.,
Director of Public Health.

Concerning anesthesia administration in California.

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco,
January 14, 1936.

James P. Dobyns, Managing Editor,
Hospital Management,
612 North Michigan Avenue,
Chicago, Illinois.

Dear Sir:—I have your communication of the 3rd instant in which you ask certain questions concerning anesthesia administration in California.

In reply please be advised that this office has heretofore interpreted the Medical Practice Act of this State to include anesthesia administration as part of the practice of medicine, and as such to be carried on only by medically licensed practitioners.

We have also expressed the view that it is sufficient that a doctor of medicine be in charge of the administration of anesthetics though the administration of anesthetics be by an assistant, provided the responsibility for the giving of the anesthetics is that of the licensed person, that the person actually administering the anesthetic do so as the assistant or "extra hands" of the licensed person, and that the assistant follow instructions of the licensed person and not exercise independent judgment in the diagnosis, treatment or condition of the patient. We have also expressed the view that a lay anesthesiologist may not charge the patient directly for the giving of the anesthetic, as well as that such charge could not be made by a hospital. A charge for the giving of an anesthetic would, in most instances, result in the corporate practice of medicine. In other words, we have stated that the giving of an anesthetic as well as the right to charge for the same is personal to the licensed practitioner.

Opinions of this office heretofore rendered indicate that there is no restriction upon who may assist in the administration of anesthetics as long as the administration is by or under the direction of a licensed practitioner.

Very truly yours,

U. S. WEBB, *Attorney-General.*
By LIONEL BROWNE, *Deputy.*

Concerning "California and Western Medicine" comments on federal survey of chronic diseases.

TREASURY DEPARTMENT
UNITED STATES PUBLIC HEALTH SERVICE

January 23, 1936.

To the Editor:—I want to take this opportunity of thanking you for the wonderful support CALIFORNIA AND WESTERN MEDICINE has given to the U. S. Public Health Service survey of chronic diseases and physical impairments. I assure you that we realize the value of this means of advising the medical profession of the intent and purposes of the survey.

Mr. Sharp, regional publicity director, has advised me that both Washington, D. C., and Detroit offices of the survey are anxious to have copies of the magazine and the extensive article you so kindly published. The Government requests such things, but fails to furnish a means of remuneration, and I am wondering if you publish sufficient copies, to contribute two additional ones to this office in order that we may comply with the requests.

Again assuring you of our appreciation for the support given, I remain

Very truly yours,

DR. ARTHUR HIERONYMUS,
State Supervisor.

208 Builders Exchange Building,
Hobart and Webster Streets, Oakland.

(Note.—Copies were sent.)

Concerning donation to Barlow Medical Library.

December 20, 1935.

Dear Doctor Warnshuis:

The check received from the California Medical Association for $129.50 as an additional gift to the library is much appreciated, and the organization desires me to express thanks for this additional gift.

The gift of the California Medical Association has enabled us to add many books to the library that would not have been possible otherwise, and, we trust, has enabled us to be of greater use to the members of the State Association as well as our own county members.

Yours, with many good wishes.

MRS. MARY E. IRISH, *Librarian.*

Concerning donation to Lane Library.

STANFORD UNIVERSITY
Office of the President

December 20, 1935.

My dear Doctor Warnshuis:

May I through you thank the members of the California Medical Association on behalf of the University for the recent check for $129.50 to be credited to the Lane Library Book Fund.

With much appreciation and all good wishes, I am,

Faithfully yours,

RAY LYMAN WILBUR, *President.*

* * *

LANE MEDICAL LIBRARY
Sacramento Street at Webster
San Francisco, California

December 19, 1935.

My dear Doctor Warnshuis:

I was so pleased to receive your check of $129.50. The generous gifts from the California Medical Association have been such a help during this period of curtailed income, and I assure you that we are most appreciative of the assistance. Please accept the thanks of the library staff, and our cordial holiday greetings.

Very truly yours,

LOUISE OPHULS, *Medical Librarian.*

Concerning charts illustrative of California taxation.

CALIFORNIA STATE CHAMBER OF COMMERCE

San Francisco,
January 17, 1936.

Members, California Medical Association:

In an effort to bring home to all of the people of the State the alarming condition resulting from the growing cost of government, the State Chamber of Commerce is issuing a series of simple charts, such as the attached, which are attracting widespread attention.

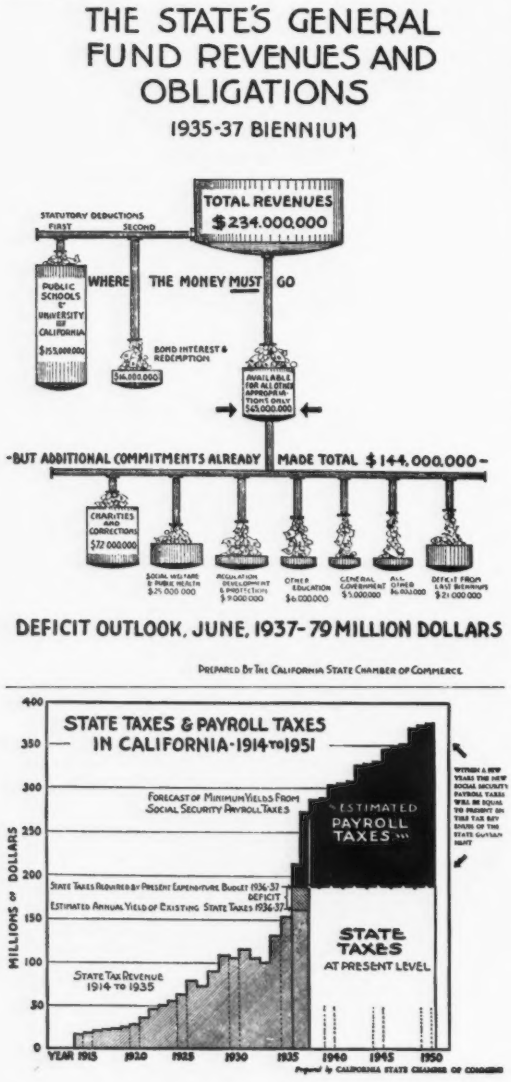
This is part of a campaign for general public education, and the story told by each of these charts cannot be too strongly stressed. We want to ask the coöperation of your publication in reprinting as many of these charts as you can.

We feel that everyone, no matter how specialized his interests, should be made to realize the meaning of the tax situation as revealed by these charts, each of which is based upon up-to-date and accurate information.

Very truly yours,
W. H. SLOANE, *General Manager.*

* * *

The table and charts which came with the above letter, and which have an indirect relationship to medical economics, follow:

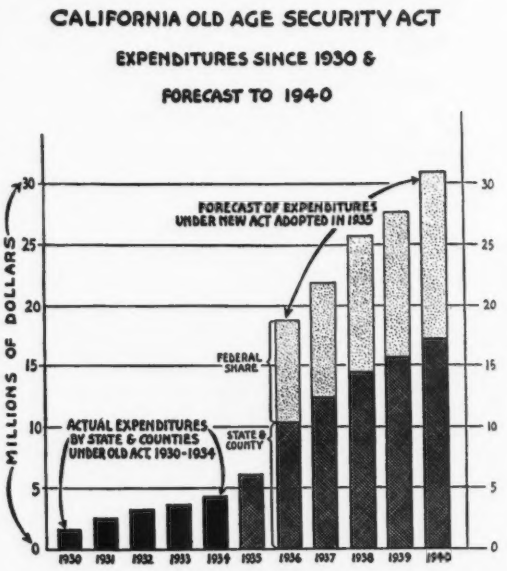


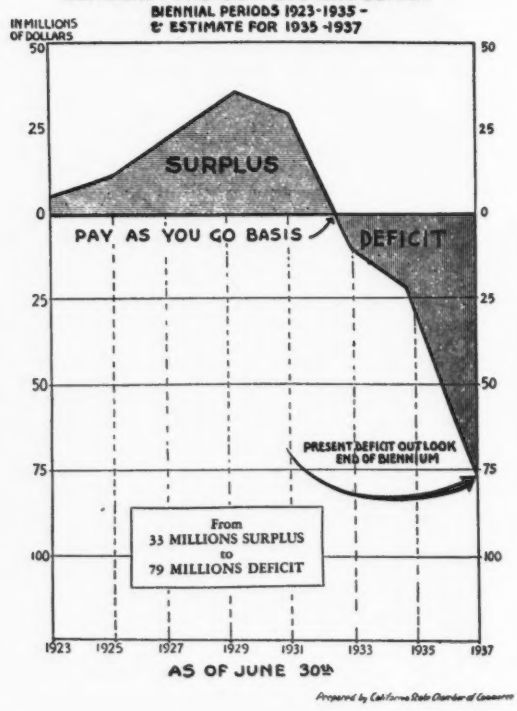
California Taxes to Federal Government Analyzed.

The California State Chamber of Commerce has released for publication the following statement:

Federal taxes collected from residents of California amount to more than $150,000,000 annually, according to a statement issued by the California State Chamber of Commerce.

Californians paid to the Federal Government $57,469,209 in income taxes and $17,091,635 in liquor taxes during the





fiscal year ending June 30, 1934, according to the statement which was accompanied by a graphic chart illustrating the variety of federal revenue collections in this State at the present time.

Federal taxes collected in California are:

Total, all sources	$151,946,264
Income taxes	57,469,209
National Industrial Recovery Act	7,589,163
Estate tax	5,920,139
Gift tax	374,000
Liquor tax	17,091,635
Tobacco taxes	10,251,560
Flour—Mixed	554
Oleomargarine	138,658
Narcotics	26,766
Stamp taxes (documents, stock transfers, etc.)	1,691,120
Manufacturers' excise tax	33,275,015
Admissions—Theaters, cabarets, etc.	1,136,557
Club dues	607,226
Telephone, telegraph, radio messages	956,759
Oil pipe-lines	825,695
Safe deposit boxes, leases	282,677
Checks	3,597,648
Pleasure boats	12,736
Miscellaneous	55,609
Subtotal	141,302,729
Agricultural adjustment taxes	10,643,535



SPECIAL ARTICLES

POLIOMYELITIS FOLLOWING VACCINATION AGAINST THIS DISEASE†

By J. P. Leake, M.D.*

During the past year in the United States, several thousand individuals, mostly children, have received subcutaneous and intracutaneous injections of treated poliomyelitis virus in the hope of acquiring immunity against the natural disease. The two different forms of treatment to which the virus was subjected were intended to render it innocuous when thus used as a vaccine. Through those responsible for the production of these vaccines, through several health officers and through others, word has come to the United States Public Health Service of the development, at suggestive intervals following these injections, of cases of paralytic poliomyelitis with high fatality. Though possibly subject to some correction, it is believed that the following statements represent closely the facts in each case:

1. A boy, aged five years, had his first symptoms of poliomyelitis six days after receiving the second dose of vaccine A in the left arm, the first dose having been given in the same arm twenty-seven days before the second. Paralysis began in the left arm the day after onset, and death occurred after an illness of three days.

2. A girl, aged twenty-one months, received the second dose of vaccine A in the right arm twelve days after the first dose, and the onset of poliomyelitis occurred six days after the second dose. Paralysis began in the right arm three days later, and death occurred five days after the onset.

3. A boy, aged four years, had his onset of poliomyelitis eight days after the first dose of vaccine A in the left buttock, and one day after the second dose at the same site. Paralysis began in his right leg two days later and is at present, after three months, confined to that extremity, though there is hope of ultimate nearly complete recovery.

4. A girl, aged eight years, had her onset of poliomyelitis eight days after the first dose of vaccine A in the left arm, and one day after the second dose in the same arm. Paralysis began in the arm two days later, and death occurred after an illness of three days.

5. A boy, aged eight years, had his onset of poliomyelitis eight days after the first and only dose of vaccine A in the left arm. Paralysis began in the right arm two days later, and remained as a deltoid paralysis at last accounts.

6. A boy, aged five years, had his onset of poliomyelitis nine days after the first and two days after the second dose of vaccine A in the arm. Arm paralysis began two days later, and death occurred after an illness of three days.

7. A boy, aged ten years, had his onset of poliomyelitis ten days after the first dose of vaccine A in the left arm and three days after the second dose in the same arm. Paralysis began in the right arm the next day, and death occurred after an illness of three days.

8. A girl, aged five years, had her onset of poliomyelitis eleven days after the first dose of vaccine A in the right arm, and four days after the second dose in the left arm. Paralysis began in the left arm four days later and was still present at last accounts.

9. A boy, aged fifteen months, had his onset of poliomyelitis thirteen days after a dose of vaccine B, and developed general weakness four days later, which persisted at the last report.

10. A boy, aged five months, had his onset of poliomyelitis fourteen days after a dose of vaccine B, and paralysis was first noticed nine days later. This paralysis persists at the last report.

11. A girl, aged six years, had her onset of poliomyelitis fourteen days after the first, and seven days after the second, dose of vaccine A in the arm. Paralysis began in the left arm three days later, and complete recovery was questionable at the last report.

12. A youth, aged twenty years, had his onset of poliomyelitis fourteen days after the first and only dose of vaccine B in the arm. Paralysis began in the arm two days later, and death occurred after an illness of four days. From this case poliomyelitis was transmitted to monkeys by Doctor Kessel.

Paralytic poliomyelitis was not epidemic in any of the localities at the time of the occurrence of these cases if these cases themselves are not included in the count. During the heaviest incidence of poliomyelitis in the community with the highest reported incidence, the expectation of paralytic poliomyelitis among those vaccinated within three weeks following vaccination, judging by its occurrence by age groups in the community at large, was less than one-tenth of a case, yet a case occurred. At the other periods and in the other localities cited, the chance of a case occurring among the vaccinated was much less, yet in each instance cases occurred. The likelihood of the whole series of cases having occurred through natural causes is extremely small. In none of the cases was exposure to infection outside its own area known to be of special significance.

† See California letters in this issue, page 137.

* Medical Director, United States Public Health Service, Washington, D. C.

It is believed that to many physicians this series of cases, following by intervals of from six to fourteen days the injection of one or the other of two different vaccines, renders undesirable the further use of poliomyelitis virus for human vaccination at present.

In every case in which the sequence is known, the level of the spinal cord first affected corresponded to the extremity in which the injection was made, paralysis beginning either in the same limb or in the contralateral limb. This is strong support to other evidence that the virus of poliomyelitis is transmitted along nerve fibers, since neither blood nor lymph streams would afford direct access from one extremity to the corresponding cord level. The remarkably high fatality in this series of cases was perhaps due to the part of the cord primarily infected being close to the nuclei corresponding to the muscles of respiration. The possibility is to be considered that a strain of poliomyelitis that has been subjected to prolonged monkey passage, with rather short incubation periods, is unusually virulent to man when administered by the subcutaneous or intracutaneous route. Though in a few of these cases it is possible or even probable that there was another intercurrent illness in addition to poliomyelitis, in general the preparalytic symptoms were such as would be expected in poliomyelitis naturally acquired.

In forming a judgment as to the applicability of a poliomyelitis vaccine, the not inconsiderable local and general reactions following its use need to be taken into account.[1] It is also noteworthy that the appearance of neutralizing antibodies in the blood after the injection of poliomyelitis virus is very uncertain evidence of parallel immunity to the natural disease.[2]

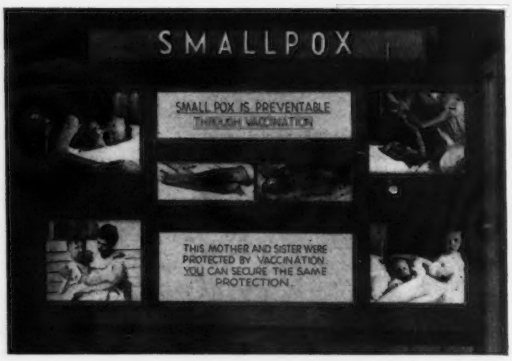
Although any one of these cases may have been entirely unconnected with the vaccine, the implication of the series as a whole is clear.—*Journal of the American Medical Association.* December 28, 1935.

1 Gilliam, A. G., and Onstott, R. H.: Results of Field Studies with Poliomyelitis Vaccine, read before the Southern Branch, American Public Health Association, St. Louis, November 19, 1935, Am. J. Pub. Health, to be published.

2 See also Schultz, E. W., and Gebhardt, L. P.: On the Problem of Immunization Against Poliomyelitis, Calif. and West. Med., 43:112 (Aug.), 1935.

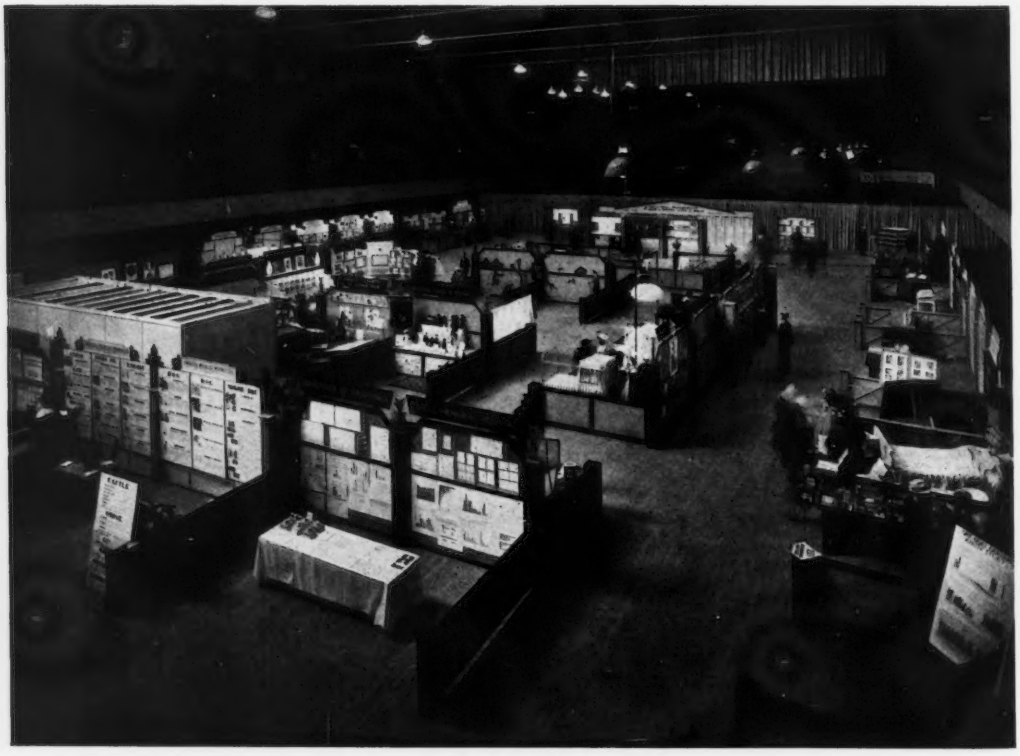
C. M. A. HEALTH INSTITUTES

Members, by these pictures, will be able to visualize the nature and extent of the Public Health Institutes that are sponsored by our Association. Their purpose being the education of the public in matters pertaining to public health and medical care for the purpose of building sound public opinion in regard to public and private health.



Smallpox Exhibit

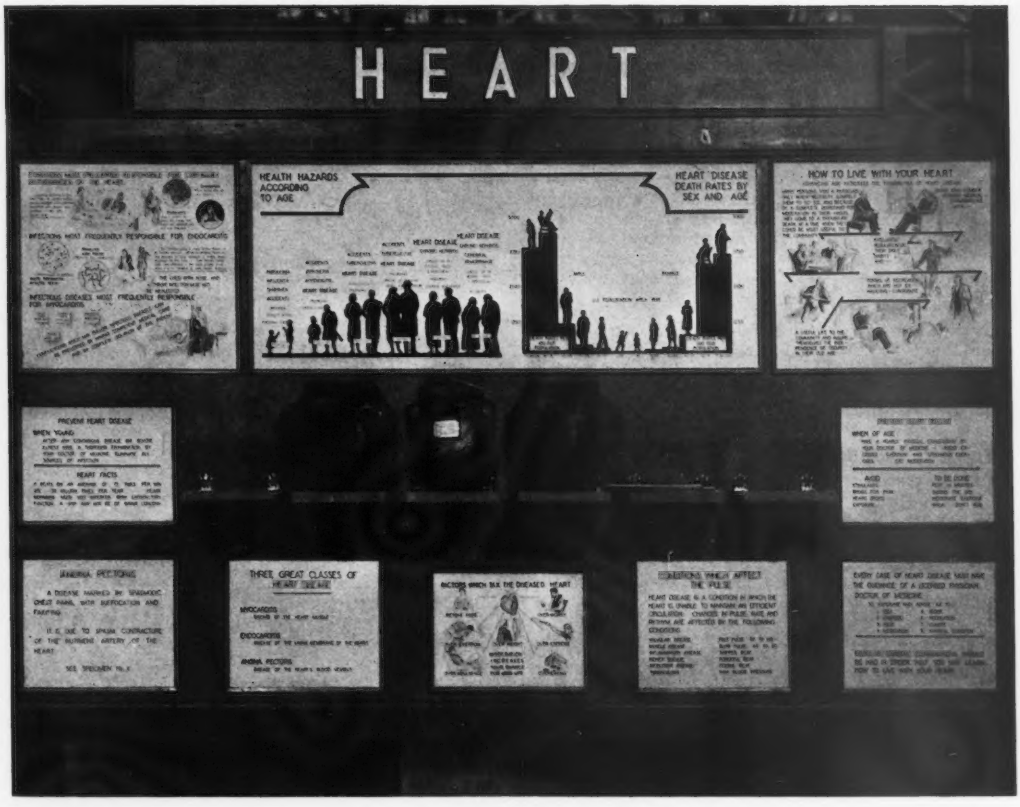
It is contemplated to conduct a series of these institutes throughout the State through county societies and auxiliaries. Details outlining the preliminary work to conduct an institute have been mailed to every county secretary. Further details may be obtained from the State Director of Public Relations.



Floor Arrangement



Tuberculosis Exhibit



"How to Live with Your Heart"

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. LX, No. 2, February, 1911

From Some Editorial Notes:

The Present Legislature.—At the time of writing, no bills harmfully modifying our Medical Practice Act or seriously menacing public health have been introduced, though, if one may judge at all by the history of past legislatures, some bills of this class will be introduced ere long. . . .

* * *

Public Health.—The President, Mr. Taft, in his message to the Congress, makes the following statement in regard to public health legislation: "In my message of last year I recommended the creation of a Bureau of Health, in which should be embraced all those government agencies outside of the War and Navy departments which are now directed toward the preservation of public health or exercise functions germane to that subject. I renew this recommendation." That should silence a good deal of adverse talk; but it will not. . . .

* * *

Progress in Thoracic Surgery.—Differential pressure is still the all-absorbing problem of thoracic surgery. If this question is satisfactorily solved and a small, convenient, ever-ready apparatus evolved, the technique of surgery of the thoracic cavity will make rapid strides. . . .

* * *

Advertising Once More.—Why, do you suppose, any manufacturer pays this Society good money for space in your *Journal* in order to set forth the merits of his goods? Do you think it is just a way he has of getting rid of his superfluous money, or do you regard him as a peripatetic philanthropist? He is not. He has something that you may need, that it may be to your advantage to know about and that he hopes he may sell to you. It is distinctly to your advantage to read the advertising pages of your *Journal* and to see what things are there offered to you; it is a little difficult, in this world, at least, to know too much and you might as well know all you can—especially when it does not cost you any more. Everything advertised in this *Journal* is honest and exactly as represented. . . .

* * *

Curious Delusions.—It is singular how people who wish to sell things to eat or drink seem to have the delusion that the particular thing they wish to sell has most wonderful therapeutic value! Foodstuffs of the most simple composition become wonderful remedies in the expert hands of the advertisement writer; even water can become a cure-all. . . .

* * *

Medical Charity.—The vexing problem of the abuse of medical charity, or the "dispensary evil" has grown lustily for a generation. It became so bad in New York that in 1898 the Dispensary Law was passed and all dispensaries required to be licensed by the State Board of Charities. This has only partly corrected the evil. . . .

* * *

Marvelous Bacteriology.—During the past few years attempts have been made to bring about a closer relationship between the medical and pharmaceutical professions, with a fair measure of success, and it is not at all uncommon to see pharmacists and expert chemists contributing to our various medical journals. The dental

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

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BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Theft of a medical calling kit and its contents, valued at $135, from an automobile owned by Dr. Merrill Hollingsworth of Santa Ana, was reported to the Santa Ana police yesterday. Included in the loot taken was some morphin and hypodermic needles." (Orange *News*, December 30, 1935.) Similar circumstances have been mentioned in previous news items, showing how sneak thieves are always watching an opportunity to rob a doctor's car.

"The Shasta County Board of Supervisors is debating the adoption of a resolution requiring the presence of a physician at every birth in the Shasta County Hospital. Such a requirement was recommended by the 1935 Shasta County grand jury in the final report filed yesterday. District Attorney Glenn D. Newton was instructed yesterday by the Board to investigate the legality of such a requirement." (Sacramento *Bee*, January 10, 1936.)

"Police Judge E. J. Tyrrell of Oakland yesterday continued the arraignment of Dr. J. Douglas Thompson, chiropractor and 'radio doctor' on a charge of falsely advertising a 'diagnostic fluid,' until Saturday morning, after Joe Brown, San Francisco attorney, notified the court that he had been retained by Thompson and would not be able to appear. Doctor Thompson, who is at liberty on $500 cash bail, was not in court. The chiropractor, who maintains offices at 330 Fifteenth Street, surrendered Wednesday on a warrant sworn to by C. B. Heiser, Pure Food and Drug Inspector for the State Department of Public Health, on charges that Doctor Thompson sold bottles of a preparation known as 'Dubla,' accompanied by pamphlets claiming that the fluid could be used by purchasers to detect acidity of the blood, as well as the presence of pleurisy, hay fever, bronchitis, asthma, and tuberculosis in their early stages. Conviction on the charge carries a maximum sentence of a $500 fine or six months in jail, or both." (San Francisco *Chronicle* (East Bay Edition), January 10, 1936.)

"Police Judge Oliver Youngs of Berkeley yesterday set January 16 for the preliminary examination of Dr. Samuel Twain, Berkeley physician and owner of a clinic at University Avenue and Grant Street, who pleaded not guilty to two counts of violating the State Narcotic Act. Doctor Twain appeared before Judge Youngs to answer charges brought by the State Narcotic Division of keeping no records of his prescriptions and of falsifying records to provide morphin in the name of his dead father-in-law." (San Francisco *Chronicle* (East Bay Edition), January 9, 1936.)

"Dr. John Colbert, an American resident in Tientsin, China, was arrested today by American authorities on a charge of attempting to poison his wife, Rueter's News Agency reported tonight from Tientsin. . . . After the preliminary hearing, Doctor Colbert was said to have been freed in the high bail of $25,000." (Press dispatch dated London, December 25, 1935, and printed in the San Francisco *Examiner*, December 26, 1935.) The records of the Board of Medical Examiners show Dr. John Colbert, a graduate of St. Louis University in 1903, was licensed in California in 1914.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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